No. 93-120-CFX
Status: GRANTED

Docketed:
July 20, 1993

Title: Thomas Jefferson University, dba Thomas Jefferson University Hospital, Petitioner
v.
Donna E. Shalala, Secretary of Health and Human Services

Court: United States Court of Appeals for the Third Circuit

Counsel for petitioner: Gaynor,Jr.,James M.

Counsel for respondent: Solicitor General

Entry	Date	Note	Proceedings and Orders
1	Jul 20 1993	G	Petition for writ of certiorari filed.
3	Aug 17 1993		Order extending time to file response to petition until September 20, 1993.
4	Sep 16 1993		Order further extending time to file response to petition until October 20, 1993.
5	Oct 20 1993		DISTRIBUTED. November 5, 1993 (Page 1)
6	Oct 20 1993	X	Brief of respondent Donna Shalala, Secretary filed.
7	Dec 15 1993		REDISTRIBUTED. January 7, 1994 (Page 27)
8	Jan 10 1994		Petition GRANTED.
			**********
9	Feb 3 1994		Record filed.
		*	Partial proceedings United States Court of Appeals for the Third Circuit.
10	Feb 9 1994		Record filed.
		*	Original record proceedings United States District Court for the Eastern District of Pennsylvania (BOX).
11	Feb 24 1994		Joint appendix filed.
12	Feb 24 1994		Brief of petitioner Thomas Jefferson University filed.
13	Feb 24 1994		Brief amici curiae of American Hospital Association, et al. filed.
14	Feb 24 1994		Brief amici curiae of Ohio, et al. filed.
15	Mar 4 1994		CIRCULATED.
16	Mar 7 1994		SET FOR ARGUMENT MONDAY, APRIL 18, 1994. (1ST CASE).
17	Mar 30 1994	X	Brief of respondent Donna E. Shalala, Secretary Health and Human Services filed.
18	Mar 30 1994		Lodging consisting of 3 documents received from the Solicitor General.
19	Apr 11 1994	X	Reply brief of petitioner Thomas Jefferson University filed.
20	Apr 18 1994		ARGUED.

93-120

No. ——

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

THOMAS JEFFERSON UNIVERSITY
d/b/a THOMAS JEFFERSON UNIVERSITY HOSPITAL,
Petitioner,

v.

DONNA E. SHALALA, Secretary
Department of Health and Human Services,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

As it is relevant to this action, the Medicare Act and regulations provided that hospitals furnishing services to Medicare beneficiaries should be reimbursed for the "reasonable cost," including direct and indirect costs, of such services. The clinical training of residents in this country has traditionally taken place in hospitals, and the Medicare program has always recognized that services provided by residents to Medicare beneficiaries relate to patient care and thus the costs of those services are includable in a hospital's "reasonable costs." Teaching hospitals that operate graduate medical education programs have increased costs which are necessary in delivering health services to Medicare beneficiaries. Until communities undertake to bear those costs, Congress directed that the Medicare program share appropriately in the costs of such graduate medical education activities. Regulations implementing the Medicare program provide, however, that costs cannot be "redistributed" from educational units to patient care units, although "redistribution" is not defined. Here, the Hospital, which is owned by an entity which also owns a medical school, claimed certain indirect costs of its related Medical School necessarily incurred in the operation of the Hospital's approved graduate medical education programs. The Secretary created an irrebuttable presumption that because those costs had not previously been claimed for reimbursement by the Hospital, they necessarily had been borne by the community (the Medical School) and therefore the Hospital's claim for reimbursement for the costs was a prohibited "redistribution." The question presented for review is:

1. Whether the Secretary's presumption of community support for programs based on a hospital's failure to claim the costs of those programs in the past, and her decision thereafter to deny payment of those costs on the grounds that they are an impermissible "redistribution" is arbitrary, capricious, an abuse of discretion and not in accordance with law.

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Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

Petitioner Thomas Jefferson University d/b/a Thomas Jefferson University Hospital (the "Hospital") respectfully requests that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Third Circuit, entered on April 21, 1993.[1]

OPINIONS BELOW

The United States Court of Appeals for the Third Circuit issued a judgment, but no opinion. The judgment is not reported, and is reprinted in the Appendix at 1a.

[1] All parties are named in the caption. Thomas Jefferson University is a private, not-for-profit educational institution. Therefore, no Rule 29.1 statement is required.

The opinion of the United States District Court for the Eastern District of Pennsylvania is not reported. It is reprinted in the Appendix at 3a.

There are two administrative decisions concerning this case. The Provider Reimbursement Review Board ("PRRB") is the administrative tribunal with jurisdiction to hear and review Medicare reimbursement disputes. Its decision in this matter, PRRB Dec. No. 90-D5, is reported in Medicare & Medicaid Guide (CCH), ¶ 38,276 (Nov. 17, 1989), and is reprinted in the Appendix at 38a. The Administrator of the Health Care Financing Administration ("HCFA") is the agent of the Secretary of the Department of Health and Human Services (the "Secretary") with authority for reviewing PRRB administrative determinations. Decisions of the Administrator constitute final agency action. The Administrator's decision is reported in Medicare & Medicaid Guide (CCH), ¶ 38,353 (Jan. 18, 1990), and reprinted in the Appendix at 28a.

JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit was entered on April 21, 1993. This Court has jurisdiction to review the judgment of the court of appeals by writ of certiorari pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Petitioner asserts that the Secretary's interpretation of regulations concerning the proper reimbursement for graduate medical education ("GME") costs was arbitrary, capricious, an abuse of discretion and not in accordance with law. The relevant statutory section, 42 U.S.C. § 1395x(v)(1)(A), and regulations, 42 C.F.R. §§ 413.85(a), (c) and (g), and 42 C.F.R. § 413.17(a), are set forth in the Appendix at 61a, 62a, and 63a, respectively.

STATEMENT OF THE CASE

Petitioner brought suit in the district court under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, commonly known as the Medicare Act. Jurisdiction in the district court was proper pursuant to 42 U.S.C. § 1395oo(f).

Thomas Jefferson University is a private, not-for-profit educational institution which operates, among other things, the Jefferson College of Medicine (the "Medical School") and the Thomas Jefferson University Hospital (the "Hospital"), a 700-bed teaching hospital. The Hospital is the licensed operator of GME programs (programs for the medical training of interns and residents) involving various medical specialties and subspecialties for 320 full-time equivalent residents. (8a). The Hospital's GME programs are approved, and there is no dispute that they contribute to the quality of patient care in the Hospital. (17a). This case concerns the appropriate interpretation of the Medicare statute and regulations, application of which determines the amount of Medicare reimbursement due Petitioner for operation of its approved GME programs in its 1985 fiscal year. Specifically, the question presented is whether the Hospital is entitled to Medicare reimbursement for the costs incurred by its related Medical School in support of the Hospital's approved GME programs.

There is no dispute that Congress recognized the value of GME programs in enhancing the quality of patient care in health care institutions. Until the community at large undertakes the responsibility to pay the costs associated with GME programs, Congress directed that "part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by [Medicare]." S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1943, 1977. Thus, from

the very inception of the Medicare program, it has been recognized that costs incurred by teaching hospitals for medical education programs should be treated in the same manner as all other costs, and reimbursed by the Medicare program appropriately.

At all times relevant to this case, GME program costs were reimbursed on the basis of "reasonable costs." The Medicare statute defines "reasonable costs" broadly:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services . . . .

42 U.S.C. § 1395x(v).

Applicable Medicare regulations also suggest that "reasonable costs" are to be defined broadly to include:

> all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. *It includes both direct and indirect costs and normal standby costs.*

42 C.F.R. § 413.9(c)(3) (emphasis added). The term "necessary and proper costs" is similarly defined broadly to mean "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." 42 C.F.R. § 413.9(b)(2). The regulations also provide that these general principles may be supplemented by more specific regulations providing that the "reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." 42 C.F.R. § 413.9(b)(1).

The regulations at 42 C.F.R. § 413.85 are the governing regulations for the reimbursement of costs associated

with educational activities. Section 413.85(a) provides that "a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section." Section 413.85(g) mandates that the reasonable costs of operating GME programs should be defined broadly:

> Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, *and other direct and indirect costs of the activities* as determined under the Medicare cost-finding principles in § 413.24.

42 C.F.R. § 413.85(g) (emphasis added).

The Medicare cost-finding principles set forth at 42 C.F.R. § 413.24 reinforce the conclusion that allowable educational costs are to be defined broadly. That regulation, which specifies the methods for identifying allowable Medicare costs from accounting records kept in connection with a provider's services, defines "cost-finding" as "the determination of [the cost of a particular service] by the allocation of direct costs and *proration of indirect costs*." 42 C.F.R. § 413.24(b)(1) (emphasis added).

In the preamble to final regulations issued in 1989 related to the determination of GME costs, the Secretary stated that such costs include a variety of overhead and administrative costs related to the operation of a GME program:

> The allowable costs of [graduate medical education] activities include the direct costs of salaries and fringe benefits of interns and residents, salaries attributable to the supervisory time of teaching physicians, other teachers' salaries, and the indirect costs (that is, institutional overhead, for example, employee health and welfare benefits) that are appro-

priately allocated to the particular medical education cost center.

54 Fed. Reg. 40286 (Sept. 29, 1989).

Finally, it is clear that Medicare regulations allow the Hospital to claim the costs incurred by the Medical School in connection with the operation of the Hospital's GME programs, when the Hospital and the Medical School are related by common ownership.

> [C]osts applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

42 C.F.R. § 413.17(a). The Secretary has always so interpreted the regulations. Thus, in guidelines issued to private entities who administer the Medicare program (intermediaries), the Secretary identified certain costs incurred by related medical schools which could be included in a provider's GME costs, including costs of a medical library, physician office space and clerical support. *See* Intermediary Letter 78-7 ("IL 78-7") (64a). These costs normally would be incurred directly by a hospital that operated GME programs independently of a related medical school. *Id.*

There can be no dispute, and indeed the Secretary did not dispute below, that the Medicare statute and relevant regulations allow for the reimbursement of direct and indirect GME costs, including costs incurred by a related medical school, where those costs are incurred in support of a provider's GME programs. Here, the Secretary did not deny the Hospital's claim because medical school costs cannot be claimed for Medicare reimbursement. Rather, the Secretary's denial of the Hospital's request was based on the fact that the Hospital had not claimed

these costs in periods prior to 1985. From this lone fact, the Secretary conclusively presumed that the costs at issue had previously been borne by the community and that the Hospital's claim for reimbursement constituted an impermissible "redistribution" of costs from an educational unit. In support of her decision, the Secretary relied on 42 C.F.R. § 413.85(c), which provides:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the [Medicare] program will participate appropriately in the support of these activities. Although *the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from eductional institutions or units to patient care institutions or units.*

(Emphasis added).

Despite the regulation's clear reference to support for educational "activities," the Secretary and the courts below interpreted the regulation to mean that any *costs* not previously claimed by a provider had been forever waived. (19a). According to the Secretary and the courts below, if the costs had not been claimed from the beginning of the provider's participation in the Medicare program, they presumptively had been borne by the "educational unit" (which the Secretary equated with the community), and any attempt later to identify the costs for Medicare reimbursement constitutes a prohibited "redistribution." 21a-22a).

Here, the Hospital is the operator of GME programs and the formal education of residents takes place within its facilities. (8a, 17a). The supervision and education of the residents, however, are performed by the Medical

School's faculty members who are supported, administratively, by the Medical School in this task. (39a). For a number of years, the Hospital has claimed reimbursement for the proportionate share of faculty salaries and fringe benefit costs attributable to GME teaching efforts and other hospital administrative duties. (9a). These amounts were determined through the use of activity reports completed by faculty members on a biannual basis. (9a). Since 1974, the amount of claimed salary and fringe benefit costs associated with the GME programs and with hospital administration had always been allowed by the intermediary and is not at issue here. (8a). Although the system for determining the extent of costs attributable to GME teaching efforts originally was designed to be as accurate as possible, beginning in 1984 and continuing in its 1985 cost year, the Hospital undertook to refine its cost-finding techniques to ensure that all of the costs properly attributable to the operation of GME programs were identified and claimed for reimbursement. (9a). Thus, in 1985, the Hospital engaged a national accounting firm to conduct a cost study to identify all of the Medical School costs incurred in support of the Hospital's GME programs, in addition to the costs of faculty salaries and fringe benefits. (9a).

The 1985 cost study identified two categories of costs: the IL 78-7 costs (*i.e.*, costs related to faculty support) and indirect costs (*i.e.*, Medical School overhead costs, such as general and administrative costs that support general departmental functions of the Medical School and that are a necessary function of the GME programs). (40a). The cost study was the basis for the Hospital's 1985 claim for reimbursement and resulted in an increased claim for GME and Medical School faculty administrative costs over previous years' claims. (9a-10a).

The Hospital's 1985 request for additional GME program reimbursement was denied by the fiscal intermediary, an agent of the Secretary with responsibility for reviewing provider requests for Medicare reimbursement.

(10a). The Hospital then appealed to the PRRB, a tribunal within the Department of Health and Human Services, composed of five individuals knowledgeable in the field of medical cost reimbursement. (7a). The PRRB reversed the intermediary's decision and allowed reimbursement of the full costs documented in the cost study. (56a). The PRRB agreed with the Hospital that the cost study complied with the full costing requirements of 42 C.F.R. §§ 413.24 and 413.85(g) by identifying the total allowable costs incurred by the Medical School in support of the Hospital's GME activities, including direct and indirect costs. Accordingly, the PRRB found that the intermediary's disallowances were improper and that the Hospital should be permitted to claim the full amounts of GME and physician administrative costs documented by the cost study. (60a).

The PRRB specifically rejected the intermediary's argument that the cost study resulted in a redistribution of costs from the Medical School to the Hospital.

> [H]istorically, the provider has always utilized the services of faculty members of its related medical school for the supervision and education of the residents in its GME programs. Throughout its participation in the Medicare program, the provider has claimed the costs identified with these educational activities, and there is no evidence that the Intermediary ever disallowed the amounts claimed. . . . In 1985, the Provider performed an in-depth study of its GME programs in order to identify all costs related to its ongoing educational activities, and the fact that the provider did not fully identify all of the costs associated with its GME programs in prior years does not prohibit the correction of this error in the cost reporting period in contention.

(58a).

Upon review, the Secretary, acting through her agent, the Administrator of HCFA, reversed that portion of the PRRB decision that had allowed reimbursement for addi-

tional GME costs. The Administrator reasoned that since these costs had not been claimed by the Hospital in earlier cost years, they presumptively constituted a "redistribution" of costs previously borne by the "community" (here, the Medical School) to the Hospital. (34a-35a).

The Hospital timely appealed the Secretary's determination to the United States District Court for the Eastern District of Pennsylvania. There, on cross motions for summary judgment, the court determined that the Secretary's interpretation of the community support and redistribution principles of section 413.85(c) were reasonable and entitled to deference. (24a).

The district court's Memorandum and Order was filed on May 1, 1992. On June 22, 1992, the Hospital timely appealed the district court's decision to the court of appeals. In a judgment entered on April 21, 1993, the court of appeals affirmed, without opinion, the district court's decision.

REASONS FOR GRANTING THE WRIT

I. THE THIRD CIRCUIT'S JUDGMENT SHOULD BE REVIEWED BECAUSE IT CONFLICTS WITH THE DECISION OF THE SIXTH CIRCUIT INTERPRETING THE SAME REGULATION

The Third Circuit's judgment affirming the district court's decision here should be reviewed because it is directly contrary to a decision of the United States Court of Appeals for the Sixth Circuit, interpreting the same regulation under virtually identical circumstances. Without this Court's review, the conflicting results in these two cases will stand, and administration and interpretation of this important aspect of the Medicare program will in the future depend on the fortuity of where a hospital is located. This is more than a merely hypothetical concern. There is currently at least one case pending before the United States Court of Appeals for the Eighth Circuit raising this exact issue. *University of Minnesota Hospital and Clinic v. Shalala,* Dkt. No. 93-2420. Moreover,

Petitioner's counsel is aware of several cases at various stages of the administrative appeal process which also present the issue of the proper interpretation and application of section 413.85(c).

This case is virtually identical to *Ohio State University v. Sullivan,* 777 F. Supp. 582 (S.D. Ohio 1991), *aff'd,* —— F.2d —— (6th Cir. 1993) (67a). A comparison of this case with *Ohio State University* reveals the complete inconsistency of the results. In both cases, the hospital/providers are teaching hospitals operated by a university that also operates a related medical school. *Compare Thomas Jefferson University v. Sullivan,* No. 90-2036, slip op. (E.D. Pa. May 1, 1992) (at 8a), *with Ohio State University,* 777 F. Supp. at 583. Historically, neither hospital claimed costs associated with GME programs incurred by related medical schools other than faculty salaries. *Compare Thomas Jefferson University,* at 9a, *with Ohio State University,* 777 F. Supp. at 583. In 1985, each hospital undertook a study to determine whether the hospital was recouping all costs permitted by law. The result of the studies was a determination by both hospitals that all GME costs were *not* being reported and claimed. *Compare Thomas Jefferson University,* at 10a, *with Ohio State University,* 777 F. Supp. at 583. Both hospitals then submitted cost reports seeking reimbursement for additional costs associated with operation of their GME programs.

In both cases, the hospitals' intermediaries denied the reimbursement claim, the PRRB reversed the intermediaries, and the Administrator reversed the PRRB. *Compare Thomas Jefferson University,* at 10a-11a, *with Ohio State University,* 777 F. Supp. at 583-84. Both hospitals then appealed to the appropriate district court. There the paths of the cases diverge.

The Secretary made the same arguments in both cases. The Secretary justified her action based on the determination that there had been "redistribution" of costs from an educational institution (the medical schools) to a

patient care institution (the hospitals) in violation of 42 C.F.R. § 413.85(c). *Compare Thomas Jefferson University*, at 14a, *with Ohio State University*, 777 F. Supp. at 584. In order to determine that the GME costs claimed were "redistributed," the Secretary presumed that since costs had not previously been claimed by the hospitals, the costs must have been borne by the medical schools (which in *Thomas Jefferson University*, the Secretary equated with the "community"). *Compare Thomas Jefferson University*, at 19a, *with Ohio State University*, 777 F. Supp. at 586.

In *Ohio State University*, the district court found this interpretation was unreasonable. The court pointed out that the statutory and regulatory scheme suggests that redistribution refers to *activities*, not costs. 777 F. Supp. at 586. The court also noted that the "related organizations principle" allowed for payment of costs incurred by a related organization, as though they were incurred by the hospital. *Id.* at 588. In *Thomas Jefferson University*, on the other hand, the district court, looking at these same regulations and a virtually identical factual record, found reasonable the Secretary's determination that the request for GME program costs was a prohibited redistribution. (24a) .

The losing party in both cases appealed. In this case, the Third Circuit simply affirmed, without opinion, the district court's decision, apparently adopting the reasoning of the lower court regarding the Secretary's interpretation of section 413.85(c). *Thomas Jefferson University v. Shalala*, No. 92-1513 (3d Cir. April 21, 1993) (1a). The Sixth Circuit also affirmed the *Ohio State University* trial court. *Ohio State University v. Secretary of Health & Human Services*, —— F.2d —— (6th Cir. 1993) (67a). In its opinion, the court agreed that the Secretary's interpretation of 42 C.F.R. § 413.85(c) was unreasonable and unpersuasive. (71a).

Thus, on virtually identical facts, two different courts of appeals have reached directly contrary results. Such confusion in the administration of a statutory scheme as important as the Medicare program is unacceptable. Only intervention by this Court can resolve the conflict and ensure that future cases are uniformly decided.

II. THE INTERPRETATION OF SECTION 413.85(c) BY THE SECRETARY AFFIRMED BY THE COURTS BELOW IS ARBITRARY, CAPRICIOUS AND UNSUPPORTED BY SUBSTANTIAL EVIDENCE

The Secretary denied the Hospital's claim on the ground that the reimbursement sought constituted redistribution of *costs* from the Medical School to the Hospital. In short, the Secretary created an irrebuttable presumption that unless costs had previously been claimed by the Hospital for reimbursement, they were being redistributed. (35a). *See also* 777 F. Supp. at 588. According to the Secretary, this result is mandated by section 413.85(c) which provides that:

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The Secretary interprets section 413.85(c) to mean that the *costs* at issue must have been "customarily and traditionally" claimed by the hospital. As a reading of the regulation makes clear, however, and as the courts in *Ohio State University* found, the prohibition against redistribution is contained in a sentence that begins, "the intent of the program is to share in the support of educational *activities* customarily or traditionally carried on by providers. . . ." 42 C.F.R. § 413.85(c) (emphasis added). The clear meaning of this passage is that the

program will pay for costs of activities traditionally carried on by hospitals (*e.g.*, clinical training of residents and interns), but that it will not pay for activities (*e.g.*, classroom training) traditionally carried on by educational institutions. *See Ohio State University*, 777 F. Supp. at 586 ("It is the activities which must be customary and traditional, not the provider's practice of paying for them or claiming reimbursement for them.").

That this is the proper interpretation of section 413.85(c) is evidenced by the Secretary's own actions, both with respect to her past treatment of the Hospital and her past and current interpretations of the redistribution language. In the instant case, the record is clear that the Hospital had GME program costs long before the Medicare program began. (*See* 8a). The Hospital began participating in Medicare at the program's inception in 1966 (*id.*); it did not begin claiming Medical School faculty salary costs for its GME programs until 1974. *Id.* If the Secretary's interpretation of section 413.85(c) is correct, of course, the Hospital's initial claim for reimbursement of GME costs in 1974 was a "redistribution," since, at that time, the Hospital had not "historically" claimed such costs. The Secretary did not make such a claim in 1974 with regard to Thomas Jefferson University, nor, prior to the mid-1980s, did she ever claim that any teaching hospital claiming GME costs for the first time, or simply claiming *increased* costs, was engaged in a "redistribution." Indeed, her internal operating guidelines issued to provide guidance to teaching hospitals for claiming costs incurred by a related medical school recognizes as "allowable hospital costs" the reasonable costs incurred by a related medical school in support of the hospital's GME programs. IL 78-7 (64a). Nowhere does IL 78-7 suggest that these cost claims must meet the Secretary's redistribution analysis. Nor does IL 78-7 suggest that teaching hospitals can claim as related party medical school costs only those costs which they have historically claimed. It is remarkable that neither

the concept of redistribution nor the relevant regulatory section is cited in the Secretary's internal guidelines for the proper treatment of GME costs by teaching hospitals. This absence is persuasive evidence that the Secretary's interpretation of section 413.85(c) is *not* a long-standing or consistent policy, but rather a recently-discovered tool for denying legitimate reimbursement claims.

This conclusion is further supported by the Secretary's recent rulemaking activity in this area. In 1992, the Secretary promulgated proposed regulations to amend section 413.85(c). *See* 57 Fed. Reg. 43659, 43672 (Sept. 22, 1992). In her proposed regulations, the Secretary acknowledges that the Agency has not previously provided any criteria for determining whether there has been "community support" for GME programs. 57 Fed. Reg. at 43661. Her proposed regulation does indeed purport to establish prospectively "community support" from failure to claim a cost in the past. However, the Secretary's acknowledgement that previously no such criteria existed is powerful proof that application of this presumption to the Hospital is arbitrary and capricious. If the Secretary's proposed regulations go into effect, she would, of course, be prohibited by this Court's decision in *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988), from applying the regulation to Petitioner retroactively.

The same argument applies to the Secretary's "redistribution" argument. In her proposed regulations, the Secretary offers the following criteria for determining whether a claimed cost is a prohibited redistribution:

> Redistribution of costs is defined as an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider and were considered costs of an educational institution. For example, costs for a school of nursing or allied health education that were incurred by an educational institution rather than the provider in its

> prospective payment or rate-of-increase limit base year cost report are not allowable costs in subsequent fiscal years.

57 Fed. Reg. at 43672.

Plainly, the Secretary seeks here to apply retroactively rules that she is just now promulgating. This "back door" attempt at retroactive rulemaking violates the spirit of *Georgetown* and is just as unlawful as the actual attempt there to engage in retroactive rulemaking.

The Secretary's apparent determination that regulations spelling out the criteria for determining "community support" and "redistribution" were required is further evidence that no such definitions or criteria existed previously. The Secretary's attempt to apply these definitions to the Hospital when, at the time the cost claims were made, there was no notice to the Hospital of the Secretary's interpretation of the regulation, is arbitrary and capricious.

The policy of the Medicare Act is clear. Congress sought to provide a system of medical insurance for the aged and disabled. The system designed provided that providers of medical services were to be reimbursed for their reasonable costs of furnishing needed health services to covered beneficiaries. The Secretary's decision here, affirmed by the courts below, that certain costs cannot be reimbursed because they were not claimed from the inception of the Medicare program, is flatly inconsistent with the basic purpose of the statute.

III. THE DECISION BELOW INTERPRETS SECTION 413.85(c) IN A MANNER INCONSISTENT WITH THE MEDICARE STATUTE

In promulgating the Medicare Act in 1965, Congress made clear its intent that Medicare providers were to be reimbursed, as nearly as possible, for all costs necessarily incurred in the efficient delivery of health care services

to Medicare beneficiaries. The Senate Report accompanying the Medicare Act states Congress' explicit intent:

> Although [reimbursement] may be made on various bases the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered, will not be borne by the program.

S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1943, 1976. This expression of Congressional purpose is codified in the Act where the Secretary is directed to issue regulations for determining reasonable costs under the Medicare program. 42 U.S.C. § 1395x(v)(1)(A). There, Congress directed that the Secretary's regulations

> *shall* . . . take into account both direct and indirect costs . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare].

Id. (emphasis added).

The result of the Third Circuit's judgment affirming the district court decision here is exactly contrary to Congressional intent: it shifts the costs of providing services to Medicare beneficiaries to individuals not covered by the program. *See Ohio State University*, 777 F. Supp. at 587 ("If the Medicare program did not pay its fair share of [GME program] costs, there is a likelihood that they would be shifted to non-Medicare patients in violation of the Medicare Act, 42 U.S.C. § 1395x(v)(1)(A) . . ."). Such a result is contrary to the meaning and purpose of the Medicare Act, and should not be allowed to stand.

CONCLUSION

For the foregoing reasons, Petitioner respectfully prays that the Court issue a writ of certiorari to review the judgment of the Court of Appeals for the Third Circuit.

Respectfully submitted,

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APPENDICES

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 92-1513

THOMAS JEFFERSON UNIVERSITY,
a Pennsylvania not-for-profit corporation
dba THOMAS JEFFERSON UNIVERSITY HOSPITAL

v.

DONNA SHALALA,
SECRETARY OF HEALTH AND HUMAN SERVICES [1]

THOMAS JEFFERSON UNIVERSITY,
Appellant

Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D.C. Civil No. 90-02036)
District Judge: Honorable William J. Yohn, Jr.

Submitted Under Third Circuit Rule 12(6)

April 19, 1993

Before: MANSMANN, ALITO and ALDISERT,
Circuit Judges

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[1] At the time the Final Order of the Secretary of Health and Human Services was issued Louis Sullivan, M.D., served as the Secretary of Health and Human Services. We have changed the caption to reflect automatic substitution of the named public officer pursuant to Fed. R. App. P. 43(c).

JUDGMENT ORDER

After consideration of all contentions raised by the appellant, it is

ADJUDGED AND ORDERED that the judgment of the district court be and is hereby affirmed.

Costs taxed against the appellant.

BY THE COURT

/s/ Carol L. Mansmann
Circuit Judge

Attest:

/s/ P. Douglas Sisk
P. DOUGLAS SISK
Clerk
Apr. 21, 1993

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE
EASTERN DISTRICT OF PENNSYLVANIA

Civil Action 90-2036

THOMAS JEFFERSON UNIVERSITY
d/b/a THOMAS JEFFERSON UNIVERSITY HOSPITAL

v.

LOUIS W. SULLIVAN, M.D., Secretary,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEMORANDUM AND ORDER

Yohn, J. May 1, 1992

The dispute in this case concerns the reimbursement due to Thomas Jefferson University Hospital ("TJUH" or "Hospital") for fiscal year 1985 pursuant to the provisions of Title XVIII of the Social Security Act ("Act"). The Act established the federally funded health insurance program for the elderly and disabled known as Medicare. 42 U.S.C. § 1395 et seq.

This matter is before the court on appeal from the final decision of the Health Care Financing Administration ("Administrator") acting on behalf of the Secretary of Health and Human Services ("Secretary"), denying the Hospital's claim for reimbursement of the full costs of faculty salaries and fringe benefits, the salaries and fringe benefits of the faculty's support staff and facilities costs

incurred in connection with the operation of graduate medical education ("GME") programs at the Hospital as well as indirect administrative costs for the services of other personnel affiliated with the Thomas Jefferson University College of Medicine ("Medical School"). The claimed costs in dispute total $2,861,247 of which $2,431,244 are associated directly with the GME programs, while $430,003 are related to the indirect administrative costs.[1]

The parties agree that no genuine issues of material fact exist in connection with this appeal and invite the court to resolve the dispute based upon their cross motions for summary judgment. For the reasons stated herein, the court will grant summary judgment in favor of the Secretary and deny summary judgment for the Hospital.

BACKGROUND

A. The Medicare Program

1. *Program Objectives and General Principles of Cost Reimbursement*

Congress established the Medicare program as a means to provide health insurance benefits to the elderly and disabled. The program is divided into two parts. Part A, known as the "health insurance program," provides insurance for inpatient hospital and related post-hospital services. 42 U.S.C. §§ 1395(c), 1395(d). Part B establishes a voluntary program of "supplementary medical insurance" covering physicians' charges and other medical services. 42 U.S.C. §§ 1395k, 13951 and 1395x(s). Medicare beneficiaries are entitled to receive medical services at any facility participating in the Medicare program as a "provider of services." 42 U.S.C. §§ 1395(d), 1395x(b). It is uncontroverted that the Hospital is an approved Medicare provider.

[1] At oral argument on the motions, counsel for the Hospital stated that the direct GME program costs in dispute ($2,431,244) are comprised of direct faculty salaries and fringe benefits, salaries and fringe benefits of the faculty's clerical staff and space costs. The indirect administrative costs in dispute ($430,003) represent expenses incurred by the Medical School in connection with such activities as admissions and general management of the GME program. As examples of these administrative costs the Hospital cited expenses associated with selecting residents and interns and costs incurred by the dean's office in administering the GME program.

From 1966 through 1982, Medicare reimbursed providers for "reasonable costs" incurred in delivering covered services to program beneficiaries. Reasonable cost was defined as the "cost actually incurred," exclusive of those costs "found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v). This system of reimbursement provided no incentive for providers to promote efficient and cost-effective delivery of patient care. Rather, over the years the system created a pattern of reimbursement that responded to increased costs by simply providing increased reimbursement.

Recognizing the urgent need to stem the spiraling costs associated with the Medicare program as well as to promote efficiency, Congress included within the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") provisions that imposed a ceiling on the rate of increase of inpatient operating costs recoverable by a provider. The Medicare reimbursement system was reformed further in 1983 when Congress enacted legislation providing for reimbursement of Medicare providers based upon the Prospective Payment System (PPS). The PPS is designed to enhance the Medicare program's ability to act as a prudent purchaser of services and to provide increased predictability respecting program costs. H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983), *reprinted in* 1983 U.S. Code Cong. & Admin. News 219, 351.

The PPS established fixed rates for reimbursement of costs associated with the inpatient care of program beneficiaries. Direct and indirect costs incurred in connection

with graduate medical education, however, were expressly excluded from the reimbursement system implemented under the PPS. Instead, GME costs continued to be reimbursed on the basis of reasonable cost. *Id.* at 359; 42 U.S.C. § 1395ww(h). By excluding GME costs from the PPS, however, Congress did not intend to exempt such costs completely from a system of control designed to improve predicability and neutralize cost increases. Nor did Congress intend that providers should be permitted to redistribute costs among program areas to maximize the level of reimbursement available from Medicare.

2. *Administration of the Medicare Program*

Congress delegated administration of Medicare's reimbursement system to the Secretary, in which capacity he may promulgate such regulations as are necessary to govern payments to providers. 42 U.S.C. § 1395x(v)(1)(A). In addition, from time to time the Secretary may issue interpretations of governing statutes and regulations which are collected in the Medicare Provider Reimbursement Manual.

To qualify for reimbursement under the program, providers such as the Hospital enter into agreements with the Secretary to provide services to Medicare beneficiaries. The Secretary then contracts with fiscal agents known as intermediaries to assist with program reimbursement. 42 U.S.C. § 1395(h). Intermediaries, acting as the Secretary's agents, review cost reports submitted by providers at the end of each fiscal year to make a final determination of the amount of reimbursable costs. 42 U.S.C. § 1385(g); 42 C.F.R. §§ 413.20(b), 413.24(f), 413.60. For the fiscal year at issue in this case, 1985, Aetna Life Insurance Company served as the government's fiscal intermediary for purposes of auditing the Hospital's claim.

Although the Medicare reimbursement scheme is complex, for purposes of this appeal, it can be viewed as consisting of two steps. The first step requires an identification of those costs that are "reasonable, necessary and related to patient care" furnished to both Medicare and non-Medicare patients. In essence, this step establishes the allowability of costs. The second step of the reimbursement process requires apportionment of allowable costs between Medicare and non-Medicare patients. 42 C.F.R. § 413.1 et seq. The dispute in this case centers on step one of the reimbursement process, the allowability of costs.

3. *Review of Decisions Affecting Reimbursement*

Once the fiscal intermediary has analyzed the cost report submitted by a provider, a written notice of program reimbursement is prepared setting forth the total amount of reimbursement due under the program. 42 C.F.R. § 405.1803. The notice explains how the determination respecting allowable and reimbursable costs was reached, relates the determination to the provider's claimed reimbursement and advises the provider of its right to appeal. A provider dissatisfied with the determination of the intermediary may, within 180 days, request a hearing before the Provider Reimbursement Review Board ("PRRB" or "Board"), a tribunal within the Department of Health and Human Services charged with exclusive jurisdiction over Medicare reimbursement claims. 42 U.S.C. § 1395oo.

The PRRB, composed of five individuals knowledgeable in the field of medical cost reimbursement, is appointed by the Secretary. Pursuant to the requirements of the Act, the Board must be comprised of two members representative of Medicare service providers. 42 U.S.C. § 1395oo(h). At least one member of the Board must be a certified public accountant. *Id.*

Where a provider requests and receives a Board decision in connection with a challenge to a reimbursement determination, the Secretary, acting through the HFCA Adminis-

trator, may reverse, affirm or modify the Board's decision. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1875. A provider may seek judicial review of the Secretary's final decision by means of a civil action commenced within 60 days of the date on which notice of the final decision is received. 42 U.S.C. § 1395oo(f)(1). It is undisputed that the Hospital has perfected its right to appeal and that this court properly may take jurisdiction over the matter.[2]

B. Factual Summary

Thomas Jefferson University Hospital is a 700-bed teaching hospital operated by Thomas Jefferson University, a private not-for-profit educational institution. A.R. at 26. The University was formed in 1824; an infirmary was opened the following year. A.R. at 40. In 1877, the University established a hospital facility that has been in continuous operation since that time. *Id.* The University also includes a College of Medicine, an Allied Health School and a Graduate School. A.R. at 11.

The Hospital operates graduate medical education ("GME") programs for its interns and residents in a wide variety of medical specialties. A.R. at 40. GME programs are conducted in the Hospital by faculty of the College of Medicine. A.R. at 13. Although the Hospital became an approved provider at the inception of the Medicare program in 1966, the first claim for reimbursement was not submitted until 1974. Since 1974, however, the Hospital has claimed and the intermediary has allowed reimbursement for costs associated with its GME programs. A.R. at 41.

[2] The court notes that plaintiff has failed to establish in any of the pleadings filed in this matter the date upon which notice of the Secretary's final decision was received. Defendant, however, agrees that this appeal was timely filed. *Def's. Motion for Summary Judgment*, at 18. The court will, therefore, order the plaintiff to file an affidavit stating the date upon which notice of the final decision was received for purposes of completing the record.

Between 1974 and 1983, the Hospital claimed Medicare reimbursement for three categories of costs reimbursable on a reasonable cost basis: 1) salaries paid directly by the Hospital to faculty of the Medical School for services rendered in the Hospital; 2) salaries paid directly to residents; and 3) funds transferred from the Hospital to the Medical School as payment for faculty time expended on GME program activities ("professional salaries"). A.R. at 137. Faculty time devoted to the Hospital's GME program is documented by means of a personal activity report (PAR) completed by each participating physician at six month intervals. A.R. at 137. The PARS form the basis for calculating the amount of professional salaries properly charged to the Hospital. The Hospital reimburses the Medical School for these salaries by means of an internal transfer of funds. A.R. at 138.

Coincident with the implementation in 1984 of the PPS, the Hospital undertook to review its claim for costs associated with the GME programs to determine whether it was identifying properly all costs eligible for reimbursement under the applicable policies and regulations. A.R. 143, 1239. This review resulted in an increased claim reflecting clerical costs incurred by the Medical School for activities identifiable to the GME program.[3] In 1985, in an effort to refine further its cost finding techniques, the Hospital engaged an accounting firm to conduct a study ["Cost Study"] intended to form the basis for the fiscal year 1985 reimbursement claim.

At the time the Hospital submitted its claim for GME costs incurred in fiscal year 1985, the Cost Study had not yet been completed. Anticipating that the Cost Study would substantiate an increase in reimbursable GME program costs, however, the Hospital simply increased the resident and intern costs of $4,737,219 by $4,000,000

[3] The intermediary allowed these clerical costs, but subsequently determined that such allowance was in error. A.R. at 51.

resulting in a claim of $8,737,219. A.R. at 154. The Hospital also claimed an additional $2,032,380 in indirect costs incurred by the Medical School in connection with administration of GME programs it believed would be supported by the Cost Study.

Upon initial audit of the Hospital's fiscal year 1985 claim, the intermediary allowed reimbursable costs of $5,944,958 consisting of $4,183,480 for direct GME program support and $1,761,478 for the indirect administrative costs. This amount was derived by applying an inflation factor to costs claimed by the Hospital in fiscal year 1984. The intermediary and the Hospital agreed that the question of total allowable costs for fiscal year 1985 would be revisited upon completion of the Cost Study. A.R. at 145.

The Cost Study, when completed, supported GME program costs of $6,614,724 and indirect administrative costs of $2,191,481 for a program total of $8,806,205. Although the intermediary audited the Cost Study in the spring of 1986, it nonetheless declined to reimburse the Hospital for costs documented therein alleging that the Cost Study represented an improper attempt to redistribute costs from an educational unit to a hospital unit in violation of 42 C.F.R. § 413.85.

The table below details the costs in dispute.

	Graduate Medical Education Costs	Administrative Costs	Total
Estimated Amounts Claimed by Hospital on Cost Report	$8,737,219	$2,032,380	$10,769,599
Amounts Supported By Cost Study	$6,614,724	$2,191,481	$ 8,806,205
Amounts Allowed By Intermediary	$4,183,480	$1,761,478	$ 5,944,958
Allowable Amounts in Dispute	$2,431,244	$ 430,003	$ 2,861,247

A.R. at 27.

C. Procedural History

The Hospital timely appealed to the PRRB the intermediary's decision respecting reimbursable costs. As framed by the Board, the question presented for review was the propriety of the intermediary's adjustments disallowing portions of the medical education costs claimed by the Hospital. A.R. at 26. Upon completion of an evidentiary hearing and post-hearing briefing by the parties, the PRRB reversed the intermediary's decision and allowed reimbursement of the full costs documented by the Cost Study. A.R. 25-29.

Upon review, the Administrator modified the decision of the PRRB, declaring that the Hospital was entitled to reimbursement only for "those medical education costs which it had traditionally claimed and been allowed prior to 1984." A.R. at 9.[4]

The Hospital timely filed this appeal from the Administrator's final decision seeking an order that the Secretary provide reimbursement for the full actual costs of the GME programs as well as the full actual costs related to administration of hospital departments. In the alternative, the Hospital seeks enforcement of the Secretary's decision that it is entitled to reimbursement for costs traditionally claimed and allowed, a decision the Hospital asserts entitles it to an additional $1,297,044.[5]

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[4] The Medicare Provider Reimbursement Manual states that "[t]he traditional practice followed in the past with respect to types of services rendered and the cost related thereto between providers and educational institutions shall be followed." Provider Reimbursement Manual at § 406.

[5] At oral argument, the Secretary conceded that the final decision issued in this matter failed to challenge or modify the PRRB's determination that the Hospital was entitled to the full allowable costs associated with direct faculty salaries and fringe benefits incurred in connection with the GME program as well as physician administrative services. Therefore, despite the fact the claim for reimbursement submitted in fiscal year 1985 reflected increased

D. Standard of Review

Jurisdiction to review the Secretary's final decision in a Medicare dispute is conferred upon this court by 42 U.S.C. § 1395oo(f)(1), which incorporates the standards of the Administrative Procedure Act, 5 U.S.C. §§ 551-59, and 701-06. *Monsour Medical Center v. Heckler*, 806 F.2d 1185 (3d Cir. 1986), *cert. denied*, 482 U.S. 905 (1987). Section 706 permits the court to set aside an agency's action, findings and conclusions only if they are found to be "arbitrary, capricious, and abuse of discretion or otherwise not in accordance with law . . . [or] unsupported by substantial evidence." 5 U.S.C. § 706(2)(A)-(E). Substantial evidence is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 477 (1951).

A district court, when exercising its powers of review under section 706, must accord substantial deference to the interpretation applied by the agency charged with administration of a statute or regulation. *Chevron U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984). Such deference is especially appropriate where the agency's interpretation is necessary to resolve issues raised in the context of a complex scheme of reimbursement. *Monongahela Valley Hosp., Inc. v. Sullivan*, 945 F.2d 576, 591 (3d Cir. 1991) (citations omitted). Moreover, as the *Chevron* Court observed, when Congress expressly delegates to an agency authority to fill gaps in a statute, the regulations promulgated "are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Id.* at 844. *Accord Sacred Heart Medical Center v. Sullivan*, 1992 U.S. LEXIS 3796 at *21 (3d Cir. Mar. 9, 1992).

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costs, the Secretary has entered into a stipulation with the Hospital pursuant to which these particular costs will be reimbursed. Consequently, the court need not address the Hospital alternative argument respecting reimbursement.

The court is mindful, then, in undertaking a review of the Secretary's decision, that its role in this process "is not to impose its own interpretation of the . . . regulation[s], but instead to defer to [the Secretary's] position so long as it is reasonable." *Monsour Medical Center*, 806 F.2d at 1191. Consequently, if the court finds the Secretary's interpretation reasonable, it will not be disturbed on appeal.

DISCUSSION

A. *The PRRB Decision*

In reaching its decision in favor the Hospital, the PRRB found that the Cost Study was prepared in compliance with applicable regulations and was, therefore, a valid and accurate statement of reimbursable costs. A.R. at 37. In addition, the Board concluded that the Study represented a refinement of the Hospital's methodology for determining costs associated with the GME program and rejected the intermediary's position that the Study was calculated to redistribute costs improperly from the Medical School to the Hospital. The Board opined that "[t]he fact that the Provider did not fully identify all of the costs associated with its GME programs in prior years does not prohibit the correction of this error in the cost reporting period in contention." A.R. at 38.

Finally, the Board found that the Cost Study did not result in redistribution to the Medicare program of costs previously borne by the community. Rather, the Board concluded, the record showed that the sole community support received by the University consisted of appropriations from the Commonwealth of Pennsylvania and the State of Delaware. A.R. at 38. In addition, the evidence established that these appropriations were earmarked specifically for the support of undergraduate medical education. *Id.* The Board determined that such a limitation plainly precluded a finding that these appropriations constituted community support for GME programs. A.R. at 39.

Contrary to the position taken by the Board, the Administrator found that "the Provider improperly tried to redistribute costs traditionally borne by the community, i.e., the university medical school, in violation of the regulation at 42 C.F.R. § 413.85(c) and Congressional intent." A.R. at 8.

B. Reimbursement for Costs Associated with Educational Activities

Reimbursement under the Medicare program for educational activities is governed by the regulation set out at 42 C.F.R. § 413.85(c) which states:

> *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until those communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

It is widely accepted that this regulation reflects express Congressional intent that the Medicare program should share in the costs of graduate medical education to the

extent that such activities enhance the quality of patient care and are not borne by the community. *See* S. Rep. No. 404, 89th Cong., 1st Sess. (1965), *reprinted in* 1965 U.S. Code Cong. & Admin. News 1943, 1977. *See also, St. John's Hickey Memorial Hosp. v. Califano,* 599 F.2d 803, 808 (7th Cir. 1979) (Congress plainly evidenced its intent that educational activities designed to enhance patient care should be borne to appropriate extent by the Medicare program); *Ohio State Univ. v. Sullivan,* 777 F. Supp. 582 (S.D. Ohio 1991) (same); *Board of Trustees of State Insts. of Higher Learning v. Sullivan,* 763 F. Supp. 178, 184-85 (S.D. Miss. 1991) ("Mississippi") (same).

Adopting a plain meaning approach, the court finds that costs of educational activities incurred by a Medicare provider are eligible for reimbursement under the regulation if four criteria are satisfied: 1) the costs are incurred in connection with an approved program designed to deliver training to, among others, interns and residents; 2) the program contributes to the quality of patient care within an institution; 3) the costs associated with the program have not been borne traditionally by the community; and 4) the costs associated with the program have not been redistributed from an educational institution to a patient care unit.

In concluding that the Hospital was not entitled to the level of reimbursement claimed in connection with its GME program, the Administrator determined that the Hospital had run afoul of both the community support and the redistribution criteria. Specifically, the Secretary stated that

> In this case, the Provider has attempted to claim costs historically borne by the University Medical School. From 1974 to 1983, the Provider has been reimbursed for a proportionate share of the direct faculty compensation costs. The Provider has attempted to radically expand the types of costs

claimed by the provider for educational activities. . . . Evidence in the record shows that these cost[s] have been historically borne by the community. The Medicare program was enacted to provide a hospital insurance and basic protection against the costs of hospital care for the aged, and not intended to subsidize medical education programs already supported by the community.

Consequently, the Board improperly determined that the provider's failure to claim these costs in an earlier cost year was an "error," which it was just attempting to correct. Rather, that the Provider did not claim these costs in an earlier cost year is evidence of the communities [sic] support for these activities. To allow the community to withdraw its support and pass these costs to the Medicare program would result in a redistribution of costs in violation of 42 C.F.R. § 413.85(c).

A.R. at 7.

1. *Reimbursement Pursuant to 42 C.F.R. § 413.85(c)*

In reviewing the Secretary's application of the reimbursement criteria outlined above to the facts of this case, the court addresses preliminarily the Hospital's argument that the community support and redistribution principles articulated in 42 C.F.R. § 413.85(c) should apply only to the academic or "classroom" portions of the Hospital's training programs and not to clinical training programs. The court finds such an interpretation in conflict with the plain language of the regulation.

Specifically, although captioned "educational activities," a denomination which might suggest the regulation applies only to academic programs, section 413.85(c) makes clear that the regulation also governs reimbursement for educational activities directed toward interns and residents. Such training is predominantly, if not exclu-

sively, clinical in nature. In fact, the record in this case establishes that the training of interns and residents at TJUH takes place exclusively in the Hospital. A.R. at 133.

The regulation simply contains no language evidencing an intent to distinguish between academic and clinical training for purposes of determining the allowability of costs claimed. Moreover, the Provider Reimbursement Manual makes clear that section 413.85(c) applies to both clinical and classroom training activities. *See, e.g.*, Provider Reimbursement Manual § 404.2. Consequently, the court must reject the Hospital's invitation to narrow the universe of costs to which the community support and redistribution principles apply.

It is not disputed that the GME program operated at the Hospital is approved or that it contributes to the quality of patient care.

2. *The Community Support Issue*

The decision rendered by the Secretary in this matter relied, in part, upon the community support principle as a basis for denying the Hospital's request for reimbursement of the full costs supported by the Cost Study. In reviewing the Secretary's application of this principle, the court must resolve two issues: 1) whether the definition of community support applied by the Secretary is consistent with previous pronouncements and, therefore, entitled to deference; and 2) whether the regulation evidences an intent that Medicare support for educational activities should increase in an instance in which community support decreases.

The regulation governing reimbursement for costs incurred in connection with educational activities does not define community support. At oral argument, the Secretary stated that his definition of community support is based on commonsense as well as the principles of cost reimbursement promulgated by the American Hospital As-

sociation ("AHA"). In essence, the Secretary views community support as any source of funding other than the Medicare program.

The Secretary's decision in this case considered community support to include "tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware." A.R. at 5. The court finds such a definition reasonable and entitled to deference. In addition, the court concludes that the definition applied in this case is consistent with both the AHA principles as well as the Secretary's earlier applications of the community support principle in the context of disputed claims for reimbursement of GME program costs.

For example, in *University of Minnesota Hosps. & Clinics v. Blue Cross & Blue Shield Assoc.*, Medicare & Medicaid Guide (CCH) ¶ 39,420 at 26,828 (May 29, 1991), the Secretary announced that for purposes of applying 42 C.F.R. § 413.85(c), community support consisted of "tuition and fees, Federal appropriations, Federal grants and contracts, private gifts, grants and contracts, endowment income, investment income and other income." Similarly, in the proceedings connected with the *Mississippi* case, *supra*, the Secretary took the position that community support was comprised of "State appropriations, along with tuition revenues and grants." 763 F. Supp. at 190. Finally, the AHA appears to contemplate that tuition, scholarships, grants and other private contributions may be included within the universe of community support. *See Principles of Payment for Hospital Care* § 2.302. A.R. at 67.

Having determined that the definition of community support applied by the Secretary in this case is both reasonable and consistent with earlier pronouncements, the court turns its attention to question of whether the administrative record contains substantial evidence to support the Secretary's conclusion that the costs now claimed by

the Hospital have been borne historically by the community.

At the hearing convened by the PRRB, Mark Richards, then the Associate Vice President for Finance at TJUH, testified that sources of funding for the University included appropriations from the Commonwealth of Pennsylvania and the State of Delaware as well as gifts, grants and alumni giving endowments. A.R. at 132, 142. In addition, evidence presented before the Board established that prior to the time the costs at issue in this matter were included in the Hospital's claim for Medicare reimbursement, such costs were borne by the Medical School. A.R. at 209, 217-18, 328.

Based upon these facts as well as an examination of the record as a whole, the court concludes that the Secretary's finding that increased costs for graduate medical education claimed by the Hospital in the 1985 fiscal year had been borne traditionally by the community is supported by substantial evidence and is, therefore, adequate to support the conclusion that the increased costs claimed by the Hospital for fiscal year 1985 are not allowable. Therefore, this finding will not now be disturbed. In addition, the court finds persuasive, if not dispositive, the Secretary's argument that to the extent the Hospital has never before claimed the excess costs now at issue, despite the fact that they were incurred in previous years, it is reasonable to assume the community was bearing these costs.

The Secretary's reliance upon the community support principle as a basis for denying the level of GME program reimbursement claimed by the Hospital in fiscal year 1985 also requires the court to determine whether a provider may look to the Medicare program for increased support in an instance, such as that presented in this case, in which community support decreases. Based upon the plain language of 42 C.F.R. § 413.85 as well as the

legislative history accompanying the 1983 amendments to the Social Security Act, the court is unable to conclude that the Medicare program may be tapped as a source of increased support for costs historically borne by the community.

The regulation evidences Congress' express intent that the costs of medical educational programs should be borne by the community. Recognizing, however, that such support may be wanting, the regulation also provides that "*until* [] communities undertake to bear these costs, the [Medicare] program will participate appropriately in the support of these activities." 42 C.F.R. § 413.85(c) (emphasis added). Nothing in the regulation suggests, however, that a provider may seek to compensate for a decline in community support by escalating costs claimed from the Medicare program.

Moreover, in enacting sweeping revisions of the Social Security Act in 1983, primary among Congressional objectives were stemming the spiraling costs of the Medicare program to prevent exhaustion of the fund and achieving a level of budget neutrality. *See* 1983 U.S. Code Cong. & Admin. News at 351. Consequently, an interpretation of the regulation that results in a shifting of costs traditionally borne by another source to the Medicare program would plainly conflict with legislative intent. Finally, to the extent that Congress has not evidenced its support for increased Medicare funding as a means to close financial gaps created by declining community support, the Secretary's position that such cost shifting is impermissible is entitled to deference on review.

3. *The Redistribution Question*

In addition to invoking the community support principle to support his decision, the Secretary also relied on the prohibition against the redistribution of costs from an educational institution to a patient care institution as a basis upon which to deny the Hospital's claim for in-

creased costs. Specifically, the Secretary concluded that "the Provider improperly tried to redistribute costs traditionally borne by the community, i.e., the university medical school, . . . in violation of 42 C.F.R. 413.85(c) and Congressional intent." A.R. at 8.

At the threshold of this analysis, the court must reject the Hospital's argument that the redistribution principle operates to prohibit only the impermissible shifting of "activities" from an educational unit to a patient care unit and does not apply to the shifting of "costs" for activities customarily and traditionally carried on the provider. The Secretary asserts that the redistribution principle applies to both activities and costs. To interpret the regulation otherwise, the Secretary opines, would result in a system under which "all costs for pre-existing activities may be shifted, carte blanche, to the provider from the teaching institution. This is contrary to the law and Congressional intent." A.R. at 7. Although at least one other court has adopted the interpretation of the redistribution principle espoused by the Hospital, *see Ohio State Univ.*, 777 F.Supp. at 586-87, this court is compelled to conclude that the Secretary 's interpretation finds support in the unambiguous language of the regulation and is, therefore, entitled to deference.

There can be no argument that the regulation evidences an intent that the Medicare program "should share in the support of educational activities customarily and traditionally carried on by providers in conjunction with their operations." 42 C.F.R. § 413.85(c). Equally clear, however, is the mandate that the Medicare program shall not "participate in increased *costs* resulting from *redistribution of costs* from educational institutions or units to patient care institutions and units." *Id.* (emphasis added).

The court concurs with the Secretary's conclusion that the regulation admits of only one interpretation, to wit, if the costs of activities customarily and traditionally carried on by providers in conjunction with their operations have

been absorbed by an educational unit, such costs may not later be redistributed to a patient care unit. It is clear that what the regulation prohibits is the "redistribution of costs." Any other interpretation would clearly run afoul of the principal that a regulation will be construed to give effect to its plain meaning. Moreover, despite the Hospital's protestations to the contrary, the court finds the Secretary's interpretation of the redistribution principle as applied to the facts of this case to be consistent with earlier applications in other disputes concerning the proper level of reimbursement for educational activities. *See, e.g., Ohio State*, 777 F.Supp. at 586.

It is uncontroverted that the excess costs claimed by the Hospital in fiscal year 1985 previously were borne by the Medical School. A.R. at 209, 328. Therefore, despite careful consideration of the Hospital's assertion that its increased claim represented a refinement of its cost-finding techniques rather than a redistribution of costs, based upon application of the plain language of the regulation to the facts established at the PRRB hearing, the court must agree with the Secretary's conclusion that the increased claim for reimbursement represents an impermissible redistribution of costs from an educational institution, the Medical School, to a patient care institution, the Hospital.

4. *The Related Organization Principle*

Throughout the proceedings conducted in connection with this matter, the Hospital has asserted that costs incurred by the Medical School in support of the GME programs are reimbursable pursuant to the Medicare program's related organization principle. This principle, codified at 42 C.F.R. § 413.17, is as follows:

> Cost to related organizations.
>
> (a) *Principle*. . . . [C]osts applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common

> ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

This regulation is designed to avoid payment of a profit to the provider through a related organization and to avoid payment of artificially inflated costs that may be generated by less than arms-length bargaining. A.R. at 8.

The Secretary takes the position that the related organization principle does not operate to expand the categories of costs allowable under the Medicare reimbursement system, a position with which the Hospital does not take issue. A.R. at 8; *Pl.'s Motion for Summary Judgment* at 43. At issue is the application of the principle to the facts of this case.

Specifically, the Secretary asserts that 42 C.F.R. § 413.17 is a general regulation applied at the threshold to all costs incurred by a related organization in delivering patient care. Consequently, the Secretary reasons, even if the excess costs now in dispute were allowable under the related organization principle, the more specific regulation governing educational activities, 42 C.F.R. § 413.85(c), would then apply, thereby prohibiting reimbursement of costs incurred by a related organization if such costs represent a redistribution from a related educational institution to a patient care institution.

By contrast, the Hospital asserts that the excess costs presently in dispute would have been eligible for reimbursement had they been incurred directly by the Hospital in delivering educational activities to its residents and interns. Therefore, the Hospital concludes, these same costs are reimbursable pursuant to 42 C.F.R. § 413.17 despite the fact that they were incurred by a related educational institution.

Application of the related organization principle in the manner urged by the Hospital would render the redistribution principle almost completely meaningless, a result in conflict with the most basic rules of statutory construction as well as commonsense. On the other hand, the court finds the Secretary's application of the related organization principle in light of the redistribution principle not only reasonable, but also consistent with legislative intent. Consequently, this application will be accorded deference.

CONCLUSION

Regulatory interpretation of a statute by the agency charged with its administration must be given great deference. This fundamental principle of administrative review is particularly appropirate where the agency's interpretation must be applied to resolve disputes arising under a complex reimbursement scheme such as Medicare. Absent a finding that the Secretary's application of the relevant reimbursement principles to the facts of this case is arbitrary, capricious, an abuse of discretion, not in accordance with the law, unsupported by substantial evidence or inconsistent with prior pronouncements, the court may not reject the Secretary's findings, upset conclusions based upon a reasonable interpretation of program regulations, or reverse decisions reflecting a proper exercise of agency discretion.

The court finds the Secretary's determination that the excess costs claimed by the Hospital for fiscal year 1985 represent an impermissible attempt to redistribute costs historically borne by the community, in this case the University's Medical School, is supported by substantial evidence and is reasonable. Consequently, the Secretary could properly conclude that the increased costs claimed for faculty salaries and fringe benefits, the salaries and fringe benefits of the faculty's clerical staff and facilities costs in connection with the operation of the Hospital's

GME program ($2,431,244) as well as the indirect administrative costs incurred by the Medical School for GME program related activities ($430,003) are not reimbursable under the Medicare program.

An appropriate order follows.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT
OF PENNSYLVANIA

Civil Action 90-2036

THOMAS JEFFERSON UNIVERSITY
d/b/a THOMAS JEFFERSON UNIVERSITY HOSPITAL

v.

LOUIS W. SULLIVAN, M.D., SECRETARY, DEPARTMENT
OF HEALTH AND HUMAN SERVICES

ORDER

[Filed May 1, 1992]

AND NOW, this 1st day of May, 1992, upon consideration of the parties' cross-motions for summary judgment, the responses thereto, the administrative record created in connection with this matter and oral argument presented by the parties, and for the reasons set forth in the accompanying memorandum, IT IS HEREBY ORDERED that

1. Plaintiff shall submit, within 10 days of the date of this order, an affidavit setting forth the date upon which the final decision of the Secretary denying reimbursement of certain costs claimed by the Hospital for fiscal year 1985 was received.

2. Plaintiff's motion for summary judgment is DENIED.

3. Defendant's motion for summary judgment is GRANTED.

4. Judgment is entered for the DEFENDANT and this case shall be marked as CLOSED.

/s/ William H. Yohn, Jr.
WILLIAM H. YOHN, JR.
Judge

[Entered: 5-4-92, Clerk of Court]

APPENDIX D

HEALTH CARE FINANCING ADMINISTRATION
Decision of the Administrator

In the Case of:

THOMAS JEFFERSON UNIVERSITY HOSPITAL,
Provider

vs.

AETNA LIFE INSURANCE COMPANY,
Intermediary

Claim for: Provider Cost Reimbursement Determination of Reasonable Costs for Cost Reporting Period(s) Ending 06/30/85

Review of: PRRB Decision No. 90-D05

Dated: November 17, 1989

This case is before the Administrator, for review of the Provider Reimbursement Review Board's (PRRB) decision. The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo]. The parties were notified of the Administrator's intent to review the PRRB's decision. Comments were received from the Bureau of Policy Development (BPD), the Intermediary, and the Provider. Accordingly, this case is now before the Administrator for final agency review.

ISSUE

The issue involves certain graduate medical education (GME) costs claimed by the Provider. The Provider claimed these costs as a result of a cost study it conducted

to determine reimbursement for medical education costs in 1985.

The Board held that the Provider could claim reimbursement for the amounts of GME and physician administrative costs documented by the Provider's cost study. The Board found that the cost study resulted in the refinement of costs and not a redistribution. The Board determined that the cost study did not shift costs from the medical school in violation of the regulation.[1] The Board in coming to this conclusion defined "redistribution" with respect to educational "activities" and not the "costs" associated with the activity. The Board found that the Provider's failure to claim these costs prior to 1984 was an "error" which could be corrected without violation of the redistribution principle.

Additionally, the Board held that Intermediary Letter (I.L.) 78-7, which is a statement of Medicare policy on this issue, implies that the medical school support items can be included in the cost determination without influencing redistribution, and, therefore, supports the Board's decision. Accordingly, the Board found that the Medicare Program is not, by this decision, incurring additional costs previously borne by the community.

Comments

BPD requested that the Board's decision be modified to allow only the direct faculty compensation costs traditionally borne by the Provider. The Board has incorrectly determined that the Provider's cost study did not shift costs from the medical school in violation of the community support and redistribution principle set forth in 42 CFR 413.85. This regulation makes clear that there should not be a redistribution of costs from the educational institution to the provider. The community has undertaken to support these activities, when the costs of

[1] 42 CFR 405.421 (1985), recodified at 42 CFR 413.85.

certain educational activities have been historically borne by the medical school and they may not subsequently shift those costs to the Medicare program.

The BPD acknowledged that there may be an increase in the absolute costs incurred by the Provider over time, but that there should not be an expansion of the types of costs that a Provider incurs for educational activities. Since the Provider historically identified and only claimed the costs for a proportionate share of direct faculty compensation costs, the remaining costs at issue are not allowable.

Similarly, the related organization principle is not intended to expand the range of items and services for which a provider can claim Medicare reimbursement. The related organization principle can not be used to redistribute costs from the educational institution to the provider. Consequently, I.L. 78-7 must be read to be consistent with the specific controlling regulations on medical education costs. Costs recognizable under I.L. 78-7, would be allowable only if these costs were traditionally borne by the Provider. Further, the general and administrative costs of the medical school are never reimbursable pursuant to I.L. 78-7 or the related organization principle.

The Intermediary commented that the University's GME program predates the Medicare program. The Intermediary objected to the Board's decision on two issues; the validity of the Provider's study and the redistribution of medical education costs. The Intermediary challenged the Provider's study based on the fact it was done after the time period at issue and was based on estimates.

Additionally, the Board in an earlier Board decision [2] defined redistribution in terms of the costs not the activity.

[2] *University of Mississippi Teaching Hospital*, PRRB No. 89-D13.

The Intermediary states that the Provider's own witness acknowledged that the costs previously borne by the school were now being borne by the Medicare program as a result of the Provider's cost study.

The Provider commented that the Board's decision properly found that the methodology of the Provider's study was valid and acceptable. Likewise, the Board properly analyzed the prohibition on redistribution as activity related, not cost related. The provider has engaged and been reimbursed for GME activities since 1974. The 1985 claim represents a refinement of cost finding methodology and not a redistribution of costs in relation to activities not previously claimed by the Provider.

DISCUSSION

The record which was furnished by the PRRB has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments are included in the record and have been considered.

There are two issues before the Administrator. (1) Whether the costs disallowed by the Intermediary are a redistribution of costs from the educational institution to the hospital in violation of the regulation at 42 CFR 413.85; and, if not, (2) whether the general and administrative costs of the university medical school, claimed by the Provider, are allowable medical education costs pursuant I.L. 78-7 and the Medicare regulations.

The cost year at issue, in this case, is the first year that the Provider operated under the Prospective Payment System (PPS). PPS provides for the reimbursement of operating costs through the calculation of payment fees. Under Sections 1886(a)(4)[3] and (d)(1)(A)[4] of the Act, the costs of approved medical education activities are spe-

[3] 42 USC 1395ww(a).

[4] 42 USC 1395ww(d). *See* 42 CFR 412.1 and 42 CFR 413.113.

cifically excluded from the calculation of the payment rate under PPS. These cost are reimbursed on a reasonable cost basis and excluded from PPS as a "pass-through." Section 1861(v)(1)(a) of the Social Security Act, as amended, defines reasonable cost as the cost actually incurred. The regulation at 42 CFR 413.9 [5] requires that in determining reasonable costs the services rendered must be related to patient care.

The Provider is an approved operator of graduate medical education programs. The affiliation of the Provider and the University predates the Medicare program. Prior to 1974, the Provider's educational program was solely supported by the community, i.e., tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware. From 1974 on, the Provider has claimed a proportionate share of direct faculty compensation costs.

For the 1985 cost year, the Provider had a study conducted to identify the "full cost" of its graduate medical education program. It then sought to claim, as allowable costs, those costs which were identified by the study, but not heretofore claimed as an expense of the Provider. The Intermediary denied the additional types of costs identified by the Provider's 1985 cost study. These included clerical salary and costs, faculty-related space and non-salary direct costs and indirect costs, e.g., non-faculty departmental costs such as general and administrative costs which support general departmental functions of the Medical School.

42 CFR 413.85(a)(1) provides for reimbursement for approved educational activities engaged in by the Provider to enhance the quality of patient care in an institution. In conjunction with this, 42 CFR 413.85(c), in defining educational activities, provides that:

[5] Formerly codified at 42 CFR 405.451.

> "Many providers engage in educational activities . . . These programs contribute to the quality of patient care . . . and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. . . ." [6]

Likewise, Section 406 of the Provider Reimbursement Manual (HIM-15) states that:

> "The traditional practice followed in the past with respect to *types of services rendered and the costs related thereto* between providers and educational institutions shall be followed." (emphasis added)

The specific regulation at 42 CFR 413.85(c) and the Congressional mandate it articulates specifically refers to and prohibits the redistribution of the "costs" of the educational activities. Congress, in passing initial Medicare legislation noted:

> "Educational activities enhance the quality of care in an institution, and it is intended until the community undertakes to bear such *cost* in some way, that a part of the net *cost* of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the costs of patient care, to be borne to an appropriate extent by the hospital insurance program." [7] (emphasis added)

[6] *See* Section 404.2 of the Provider Reimbursement Manual.

[7] 89th Cong. 1st Sess., Senate Report 404, pg. 36, *reprinted in* 1965 U.S. Code Cong. & Ad. News, Vol. 1., pg. 1977. *See St. John's*

Consistent with this, the regulations at 42 CFR 413.85(c) states that:

> "Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, *it is not intended that this program should participate in increased costs resulting from the redistribution of costs from educational institutions . . . to patient care institutions . . .*" (emphasis added)

Upon the implementation of PPS and the corresponding provision for pass-through medical education costs [8], it became apparent that teaching hospitals' were attempting to claim costs not previously the responsibility of the Provider or reimbursed by Medicare.[9] These costs were an improper redistribution of teaching institutions costs to hospital medical education costs. This prohibition against the redistribution of costs was not new, as suggested by the Provider, but rather the application of established Medicare policy, to an attempt by the teaching hospitals to improperly increase reimbursement in response to the medical education pass-through provisions of PPS.

The Administrator finds that the Board erred in holding that the "redistribution" principle only related to "activities" and not "costs." Under the Board's analysis, all

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Hickey Memorial Hospital v. Califano, 599 F.2d 803 (7th Cir. 1979) [1979-1 Transfer Binder] Medicare & Medicaid Guide (CCH) Para. 29733 at 10,321. In that case the court states that:

> "The legislative history of the Medicare Act clearly shows that the Medicare program was intended to pay its share of a hospital's cost of educational activities contributing to patient care until such *costs* are borne by the community served by the hospital." (emphasis added)

[8] P.L. 97-248.

[9] Medicare Regional Intermediary Letter No. 87-9.

costs for pre-existing activities may be shifted, carte blanche, to the provider from the teaching institution. This is contrary to the law and Congressional intent.

In this case, the Provider has attempted to claim costs historically borne by the University Medical School. From 1974 to 1983, the Provider has been reimbursed for a proportionate share of the direct faculty compensation costs.[10] The Provider has attempted to radically expand the types of costs claimed by the Provider for educational activities. Congress intended that, until the community undertakes to bear such education costs in some way, the Medicare program should bear some portion of the costs of educational activities as an element in the costs of patient care. Evidence in the record shows that these cost have been historically borne by the community. The Medicare program was enacted to provide a hospital insurance and basic protection against the costs of hospital care for the aged, and not intended to subsidize medical education programs already supported by the community.

Consequently, the Board improperly determined that the Provider's failure to claim these costs in an earlier cost year was an "error", which it was just attempting to correct. Rather, that the Provider did not claim these costs in an earlier cost year is evidence of the communities support for these activities. To allow the community to withdraw that support and pass these costs to the Medicare program would result in a redistribution of costs in violation of 42 CFR 413.85(c). It would in fact be the precise activity Congress intended to prevent. To allow it would encourage the community to abdicate its commitment to education to an insurance program intended to provide care for the elderly.

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[10] The record indicates that the Provider claimed clerical and office space costs in 1984, which the Intermediary acknowledges it mistakenly allowed. The Intermediary realized its error during the Board hearing, which was beyond the time allowed for the Intermediary to reopen the cost report pursuant to 42 CFR 405.1885.

Additionally, the general and administrative costs of the university medical school would not be allowable medical education costs under any circumstance. The Provider maintains that 42 CFR 413.85 mandates the use of full costing principles using the best available statistics. As related parties under 42 CFR 413.17 (formerly 42 CFR 405.427), the Provider alleges that the full cost of medical school services related to patient care, including indirect or overhead costs, are allowable costs of the Provider.

However, the Provider, while relying on I.L. 78-7, recognizes that it does not allow for the general and administrative costs of the university medical school claimed by the Provider.[11] Specifically, I.L. 78-7 states that allowable costs incurred in the medical school for items other than faculty direct costs, applicable fringe benefits, etc. as defined above are limited to direct costs and space costs. Contrary to the Provider's contentions, the purpose of the related organization pinciple is to avoid the payment of a profit factor to the provider through a related organization and to avoid payment of artifically inflated costs which may be generated from less than arms-length bargaining. The related organization policy of 42 CFR 413.17 [12] does not expand items or services allowable under Medicare principles as the Provider would have it do. Only those costs that are incurred by the university medical school which can be directly related to the training program for the interns and residents working in the university hospital may be allowed. The general and administrative costs of the university medical school claimed by the Provider fail to meet this criteria for allowable costs.[13]

Consequently, the Provider improperly tried to redistribute costs traditionally borne by the community, i.e., the

[11] Provider's Position Paper, p. 14.

[12] *See* Section 1000 of the Provider Reimbursement Manual.

[13] I.L. 78-7.

university medical school, in violation of the regulation at 42 CFR 413.85(c) and Congressional intent. Additionally, the general and administrative costs of the university medical school, which the Provider claimed in violation of 42 CFR 413.9, 42 CFR 413.85 and I.L. 78-7, are not allowable cost.

DECISION

Accordingly, the Administrator modifies the decision of the Board. The Provider may only be paid for those medical education costs which it has traditionally claimed and been allowed prior to 1984.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 1/18/90

/s/ Louis B. Hays
LOUIS B. HAYS
Acting Administrator
Health Care Financing
Administration

APPENDIX E

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

90-D5

Case No. 86-1588

PROVIDER—THOMAS JEFFERSON UNIVERSITY HOSPITAL
PHILADELPHIA, PA

Provider No. 39-0174

VS

INTERMEDIARY—AETNA LIFE INSURANCE COMPANY

Date of Hearing—June 19 and 20, 1989

Cost Reporting Period Ended June 30, 1985

INDEX

ISSUE:

Whether the Intermediary's adjustments disallowing portions of the medical education costs claimed by the Provider were proper?

SUMMARY OF FACTS:

Thomas Jefferson University (University) is a private, not-for-profit entity which operates the Jefferson College of Medicine (Medical School) and a 700-bed teaching hospital (Provider). The Provider is the licensed operator of graduate medical education (GME) programs involving various medical specialties and subspecialties for 320 full time equivalent residents. For the cost reporting period in contention, the Intermediary made a series of adjustments disallowing amounts claimed by the Provider for the GME programs and for Medical School faculty services associated with the administration of hospital departments (Provider Exhibit 2). Based on the Intermediary's adjustments, the amount of Medicare reimbursement in dispute is approximately $815,000. The Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board (Board) pursuant to 42 CFR 405.1835ff and has met the jurisdictional requirements therein.

Background:

As the operator of the GME programs, all of the formal education of the residents takes place within the Provider's facilities. However, the supervision and education of the residents are performed by the Medical School's faculty members. Historically, the Provider has reimbursed the Medical School for the proportionate share of faculty salaries and fringe benefit costs attributable to GME teaching efforts and other hospital administrative duties. These reimbursements were made by a combination of direct salary payments to the faculty or through a transfer of funds to the Medical School for professional

services. The portion of faculty salaries related to GME and administrative services has been traditionally determined through the use of the Provider's Personnel Activity Report (PAR) system. These reports, which are completed by the faculty members on a biannual basis, were used to substantiate the amounts transferred and also formed the basis for the Provider's reimbursement claims. Until fiscal year 1985, the amount of claimed salary and fringe benefit costs associated with the GME programs and with hospital administration had always been allowed by the Intermediary.

Prior to 1984, the Provider reviewed its claims for medical education and faculty administrative costs to determine whether it was properly identifying the actual costs in accordance with Medicare policy. Based on this review, additional clerical costs associated with faculty time spent on GME were identified and claimed in its cost report for fiscal year 1984 and were allowed by the Intermediary. In an effort to refine further its cost-finding technique, the Provider engaged an accounting firm to conduct a cost study which could form the basis for the 1985 reimbursement claim. Under the full costing approach used in the cost study, two categories of costs were identified:

(1) Direct Costs—faculty-related costs which include faculty salary and fringe costs, clerical salary and fringe costs, faculty-related space and non-salary direct costs; and

(2) Indirect Costs—non-faculty departmental costs, such as general and administrative costs which support general departmental functions of the Medical School and which are a necessary function of the GME costs.

The study was completed in late 1985 and documented total GME costs of $6,614,724 and total faculty administrative costs of $2,191,481.

Because the cost study was not complete at the time the fiscal year 1985 cost report was prepared, the Provider made adjustments to its cost report (A-8 adjustments) increasing the amounts claimed for GME and physician administrative costs by $4,000,000 and $452,000, respectively. These A-8 adjustments were made to increase allowable costs by amounts the Provider estimated would be supported by the cost study. Since faculty salaries of $4,737,219 were already included in the GME cost center, the total GME costs claimed on the filed cost report was $8,737,219. The aggregate amount claimed for physician administrative services, including the A-8 adjustment, was $2,032,380. The Provider acknowledges that the estimated amounts claimed on the cost report should be reduced to the actual amounts later supported by the cost study.

When the Intermediary audited the Provider's cost report in December 1985, time constraints precluded a complete review of the cost study. To calculate GME and physician administrative costs for fiscal year 1985, the Intermediary applied an inflation factor to the costs allowed in fiscal year 1984. The application of this methodology by the Intermediary resulted in allowable costs of $4,183,480 for GME and $1,761,478 for physician administrative services. Accordingly, the Intermediary effected a series of adjustments to reduce the Provider's claimed amounts to its allowable cost determination. The following is a reconciliation of the estimated costs claimed by the Provider versus the amounts ultimately supported by the cost study and the amounts allowed by the Intermediary:

	Graduate Medical Education Costs	Physician Administrative Costs	Total
Estimated Amounts Claimed by Provider on Cost Report	$8,737,219	$2,032,380	$10,769,599
Amounts Supported by Cost Study	$6,614,724	$2,191,481	$ 8,806,205
Amounts Allowed by Intermediary	$4,183,480	$1,761,478	$ 5,944,958
Allowable Amounts in Contention	$2,431,244	$ 430,003	$ 2,861,247

Provider's Contentions:

The Provider contends that it is entitled to reimbursement for the full direct and indirect costs incurred by a related Medical School in support of GME programs carried on in the hospital. In support of this contention, the Provider cites various provisions within 42 CFR 405.421 which define allowable education costs as follows:

> (b) . . . Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution . . . .
>
> (c) . . . These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel . . . .
>
> (g) . . . For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

The Provider states that the medical education cost study performed in 1985 was designed as a cost finding tool to identify total allowable GME costs. The Provider asserts that the detailed methodology employed by the study enabled it to identify with a high degree of accuracy the full faculty related and administrative costs incurred for the GME programs and which it is entitled to claim consistent with the full costing approach specified in 42 CFR 405.421 and 405.453 and the related party rules established under 42 CFR 405.427. Under the methodology used, faculty costs were allocated through the use of the 1985 data reported by the PAR system which determined the amount and percent of time each faculty member spent among the following:

> (1) Institutional and clinical supervision of hospital-based residents and interns;
>
> (2) Clinical supervision of medical students and other paramedical specialties; and
>
> (3) The amount of administrative time relative to approved programs (By-product of faculty effort survey).

The percentage of faculty time spent in approved GME programs was used to calculate the Provider's total allowable faculty-related costs. Non-faculty departmental costs related to GME were determined based on a ratio of the number of residents and interns to the total number of students in the Medical School. The direct costs analyzed were then tested against the reasonable compensation equivalent (RCE) limits established under 42 CFR 405.482 to ensure that the claimed costs did not exceed the amounts considered reasonable by the Medicare program. In the few instances where the RCEs were exceeded, the excess was subtracted to comport with Medicare guidelines.

The Provider contends that it has presented substantial uncontroverted evidence that the 1985 cost study is re-

liable, verifiable and was conducted in accordance with Medicare policy and regulations. By contrast, the Intermediary has introduced no probative evidence as to any deficiency in the study. Moreover, subsequent to the initial audit, the Intermediary did review the cost study and found no specific problems or deficiencies in the methodology or calculations. In fact, the Intermediary acknowledged the following in correspondence to the Health Care Financing Administration (HCFA):

> During this field audit review, the auditors traced and verified the Cost Study to source records with only very minor discrepancies. All of the Cost Study methods were consistent with the internal funding method, just far more comprehensive. (Provider Group Exhibit 5, at I-B)

The Provider notes that, despite the lack of any evidentiary support, the Intermediary suggests that the PAR system, upon which the cost study is based, is somehow not reliable. In response, the Provider points out that the PAR system historically has been used as the basis for determining the percentage of faculty time spent in relation to GME activities, and is the same system that the Intermediary has audited in the past and found to be reliable in each of its prior cost reports. The Provider concludes that the Intermediary has never raised any question as to deficiencies in the PAR system in the past and, therefore, the current attack is unwarranted and unsupported.

The Intermediary also contends that the increased educational costs claimed in fiscal year 1985 resulted from a redistribution of cost, and that such redistribution is specifically prohibited under the regulations and various other policy pronouncements. Responding to this argument, the Provider contends that it has engaged in educational activities, and specifically GME programs, since at least 1974, and has claimed and been reimbursed for the costs associated with those programs throughout the 11

year period. The Provider asserts that it is the intent of the Medicare program to share in the costs of educational "activities" traditionally engaged in by providers when the community has not undertaken to bear the cost, and cites the following relevant part of 42 CFR 405.421:

> (c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these *activities.* Although the intent of the program is to share in the support of educational *activities* customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units. (Emphasis Added)

Whereas the wording of 42 CFR 405.421 is not clear as to what is meant by redistribution, the Provider notes that the regulation does focus on Medicare's intended support of "activities" traditionally carried on in the provider, which would suggest that the redistribution language is "activity" related. If the activity is one historically engaged in, the costs associated with the activity

are reimbursable. Using the Intermediary's interpretation, a cost component analysis would be necessary to determine whether the costs associated with the activity have historically been claimed. The Provider believes the Intermediary's interpretation of the regulation is impractical because such an interpretation would result in the Medicare program sharing not in the reasonable costs incurred by the provider, but rather only in the costs actually claimed by the provider at the inception of the Medicare program. The Provider argues that the categories and amounts of costs it has incurred in relation to the GME programs have increased dramatically since 1966 (e.g. College of Medicine operating costs tripled from 1972 through 1984) and, therefore, it is not practical to be bound to those categories of costs that existed when its first cost report was submitted.

The Provider also refers to the related party rules under 42 CFR 405.427. Under those rules, it is the actual costs incurred by the related organization that are reimbursable, not its charges, even if the charges are less than the costs. Thus, the only questions in related party transactions are whether the costs incurred are related to patient care services, whether they are reasonable, and whether they are the types of costs that would be reimbursable had they been incurred by the hospital directly. The Provider asserts that the regulations at 42 CFR 405.421 and 405.427 are not inconsistent, and there is no redistribution as long as the costs incurred by the Medical School are associated with programs historically carried on by the Provider and are related to patient care.

The Provider also contends that its "activity" related interpretation is further supported by the manner in which HCFA has interpreted the redistribution language. As evidence of HCFA's interpretation, the Provider refers to Intermediary Letter 78-7 (IL 78-7) in which HCFA issued guidelines for teaching hospitals claiming costs incurred by related medical schools. IL 78-7 specifically recognizes as allowable costs the reasonable medical

school costs incurred in support of GME programs. The Provider notes, however, that the IL does not state that such programs must first be evaluated to determine whether a redistribution occurred, nor is there any mention that teaching hospitals can claim as related party medical school costs only those costs which they have historically claimed. The Provider also refers to other recent HCFA correspondence, including HCFA's reply to the Intermediary in the instant case, in which no mention is made that the reporting of costs not previously claimed constituted a redistribution. Moreover, HCFA's concerns focused on (1) whether the clinical training activity was directly related to rendering patient care services, and (2) the need to determine if the community is fully supporting the medical education activities of the college or if additional participation is necessary from the Medicare program. In response to the Intermediary's inquiry in the instant case, HCFA never suggested that the Provider would not be entitled to reimbursement for costs not previously claimed.

In reference to the Board's decision in *University Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, Inc.*, PRRB Decision 89-D13, (December 29, 1988), the Provider believes the Board rightfully applied the redistribution language in upholding the disallowance of costs related to the School of Nursing and the School of Health Related Professions. In that case, the Board found that the activities being claimed related to the academic training of nurses and, in addition, were not engaged in by the provider, but rather by nonproviders. The Provider notes that it is neither claiming costs associated with nonprovider activities nor with undergraduate activities. As the licensed operator of GME programs conducted in the hospital, the Provider is claiming only those allowable costs associated with the GME programs that it has historically engaged in and for which it has historically been reimbursed.

This is not the type of situation to which the redistribution language should be applied.

Under the provisions of 42 CFR 405.421, the Medicare program will share in the reasonable costs of approved educational programs until such time as the community has met its obligation to support those programs. The Provider asserts that the community has not met its obligation of support with respect to its GME programs. Whereas the University receives appropriations from the states of Delaware and Pennsylvania, those appropriations have dropped precipitously from 35 percent of the Medical School's operating costs in fiscal year 1972 to 16 percent for fiscal year 1983. More importantly, the Provider points out that the state appropriations are not available to fund GME programs since they are limited in use to undergraduate medical education. Accordingly, the University is forced to defray the costs of residents training through its own resources. In addition to the use of endowment funds, the GME programs are also supported in part by tuition fees, which have risen 360 percent since fiscal year 1973. Since only undergraduate medical students pay tuition, these students are in effect paying for the GME programs which do not directly benefit them at that point of their education.

The Provider further argues that it is not clear whether the community support concept has any relevance to the issue of resident training. Whereas the concept of community support is based on the notion that society as a whole should undertake support of formal classroom training of doctors, nurses and other health care professionals, it is also a matter of public policy that the users of services are the ones who should support the clinical training of the providers of those services. The training of residents involves practical hands-on experience which relates directly to diagnosis and treatment and, thereby, directly benefits patients. Accordingly, it is appropriate that the costs of these efforts be borne by the patient.

The Provider contends that its cost study has accurately identified those costs related to clinical programs which directly enhance patient care and, thus, it is entitled to the full reimbursement of costs associated with its GME programs in accordance with Medicare policy and regulations.

Intermediary's Contentions:

It is the Intermediary's primary contention that the incremental education cost claimed by the Provider in fiscal year 1985 was due to the shifting of costs from the Medical School, which is a direct violation of the community support and redistribution principles set forth in 42 CFR 405.421. The Intermediary cites the following pertinent section of 42 CFR 405.421(c) to support its position:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear the costs, the program will participate appropriately in support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, *it is not intended that this program should participate in increased costs resulting from REDISTRIBUTION of costs from educational institutions or units to patient care institutions or units.* (Emphasis Added)

Whereas the issue under appeal in this case was triggered by the elaborate and expansive cost shifting which occurred in 1985, it is the Intermediary's contention that earlier redistributions of costs from the Medical School to the Provider are also relevant to this appeal. The University has a long history of being self-supporting or community supported and, prior to 1974, Medicare fund-

ing was not required. In 1974, the Provider commenced shifting costs from the community to the Medicare program. Additional cost shifting occurred in 1984 when certain clerical costs of the Medical School were included in the Provider's cost report. However, the Intermediary believes that in 1985 the Provider overstepped the bounds of the regulations and an adjustment to claimed educational costs became necessary.

The Intermediary contends that a review of regulation 42 CFR 405.421 and its legislative history clearly shows that it was the intent of Congress to reimburse only medical educational activities engaged in by providers which had not been undertaken by the community. The Intermediary notes that the reimbursement principles adopted by the Medicare program were derived from the existing reimbursement policies established by the American Hospital Association (AHA). The Intermediary refers to section 2.302 of AHA's Principles of Payment for Hospital Care which states:

> In determining reimbursable cost, a reasonable amount for medical, nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion in the interest of continuing to upgrade quality of service to the community.
>
> COMMENT . . . Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining reimbursable cost of hospital service until the community is prepared to assume this educational responsibility. Hospitals and third-party purchasers must seek methods for transferring this cost to the whole community through concerted joint effort. It must be borne in mind that nursing education traditionally has been supported by hospital income and by the service rendered by student nurses in hospitals. While financing from other methods must be developed, nothing must be done to discourage the education of increasing numbers of nurses prior to the time such cost can be transferred to other sources.

When Congress considered reimbursement mechanisms for the Medicare program, it relied on the AHA principles for guidance. Upon passage of the Medicare Act in 1965, the law was accompanied by a Congressional report which discussed the decision to make medical education an allowable cost. This document states in part:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such educational cost in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

The underlying theme throughout the language related to medical education specifically indicates that if the community supports the educational activities, then the Medicare program shall not participate.

In addition to the community support provision, the regulation also adopts the redistribution concept. In response to the Board's request for clarification on the redistribution issue, the Intermediary refers to various HCFA letters

which were prepared in response to specific medical education inquiries made on behalf of different providers (Intermediary Exhibits I-24 through I-27 and I-52). Based on its review of these letters, the Intermediary points to the following pertinent policy applications for determining the proper reimbursement of medical education costs:

(1) IL 78-7 is no longer applicable due to the implementation of the Prospective Payment System (PPS).

(2) The Medicare program has historically included certain medical education cost as allowable costs in recognition of the fact that the general community support of these activities was not fully involved.

(3) Costs incurred directly by a medical school in the operation of its education program cannot be passed through as direct cost to the hospital for PPS purposes, even though the entities are related.

(4) Activities conducted by the faculty of a related medical school that are both related to the care and treatment of the hospital's patients and furnished in support of the clinical training of interns and residents meet the requirements for Medicare reimbursement.

(5) Medical education items and services must be necessary and directly related to the rendition of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital.

(6) The policy concerning related organizations was not intended to expand the range of items and services for which a provider could claim Medicare reimbursements, or to include items and services not specifically related to patient care.

(7) Where costs for items or services related to medical education activities have historically been borne by a university medical school . . . it is our view that the community has undertaken to support these activities. Consequently, their subsequent allocation to a hospital represents a redistribution of costs from an educational institution/unit to a patient care institution/unit. In such situations, these costs are not reimbursable under the Medicare program. Likewise, if the costs of teaching physicians supervising interns and residents have been borne by a medical school and the salaries and fringe benefits of interns and residents have been paid by the provider, the hospital cannot begin claiming Medicare reimbursement for any costs to the hospital of the teaching physicians because such a change represents a redistribution of costs from an educational institution to a patient care institution.

(8) Physicians' approved educational activity services to the provider—This category includes the time a physician spends in teaching activities such as grand rounds, time spent in supervising residents in the care of individual patients with whom an attending physician relationship is not established, and time spent in activities related to other approved provider-operated educational programs.

(9) Nonallowable costs—This category would include such activities as research, supervision of residents not in an approved program, and any medical school activities not directly related to the rendition of patient care services in the hospital.

(10) Where a teaching hospital has never claimed costs incurred by a university medical school, any attempt to include such costs would be considered a redistribution of costs from the medical school to the hospital and would form a basis for the disallowance of such costs.

The Intermediary believes the above cited excerpts from various HCFA communiques fully define the meaning of redistribution or cost shifting and the explicit prohibition of such action in determining allowable medical education costs.

The Intermediary further argues that the Provider has placed undue reliance on the related organization principles under 42 CFR 405.427 and the application of IL 78-7. Whereas the related organization concept would not require an actual payment or recording of costs on the books of a provider, the Intermediary contends that the prevailing regulation in this case is 42 CFR 405.421 which covers medical education activities. Under the provisions of 42 CFR 405.421, it is the Provider that is required to be engaged in the educational activity, and the redistribution language prohibits the reclassification of expense from the Medical School to the Provider (patient care unit). The Intermediary asserts that the medical education regulation is more specific and must, therefore, be given greater weight than other regulations. With respect to the application of IL 78-7, the Intermediary refers to HCFA pronouncement that the IL 78-7 is no longer appropriate with the advent of PPS.

As a secondary argument, the Intermediary questions the validity and applicability of the Provider's cost study, which is the foundation for the costs transferred from the Medical School. In support of its contention that the study is inappropriate, incomplete and inaccurate, the Intermediary cites the following deficiencies:

(1) Failure to comply with the American Institute of Certified Public Accountants' standard for the preparation of workpapers and documentation of source data.

(2) Lack of documents which support the intention, design, development, application, utilization or implementation of the study.

(3) The principal source document used in the study (Personnel Activity Report) to compile and allocate faculty time and associated costs is fatally flawed because it is based on the historical recreation of best estimates, and excludes time spent in private patient care.

(4) The Provider's use of faculty time as the basis for allocating all other costs of the Medical School is an unsubstantiated assumption.

(5) The study relies on the obsolete application of IL 78-7 rather than the basic Medicare principles required by 42 CFR 405.453.

In summary, it is the Intermediary's conclusion that the study is flawed in its design, compilation and assumptions, and is an invalid document to be used for the purpose of shifting costs from the Medical School to the Provider, which in and of itself is not proper under Medicare policy.

CITATION OF APPLICABLE LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. **Law—Title XVIII Social Security Act:**
   - a. **Section 1861(u)** — **Provider of Services**
   - b. **Section 1861(v)(1)(A)** — **Reasonable Cost**
2. **Regulations—42 CFR 405, Subpart D:**
   - a. **Section 405.406 (Redesignated 413.20)** — **Financial Data and Reports**

b. Section 405.421 (Redesignated 413.85) — Cost of Educational Activities

c. Section 405.427 (Redesignated 413.17) — Cost to Related Organizations

d. Section 405.451 (Redesignated 413.9) — Cost Related to Patient Care

e. Section 405.453 (Redesignated 413.24) — Adequate Cost Data and Cost Finding

3. Program Instructions:

a. Provider Reimbursement Manual, Part (HIM 15-1):

Section 406 — Cost of Educational Activities —Program Participation

b. Part A Intermediary Letters (IL):

IL 78-7 — Allowance of Medical School Faculty Costs

FINDINGS AND CONCLUSIONS:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing and post-hearing briefs finds and concludes that the Intermediary's adjustments were improper and should be modified to allow for the amounts of GME and physician administrative costs documented by the Provider's cost study.

The Board finds that the GME costs identified by the Provider's cost study pertain to services related to the care and treatment of its patients and were furnished in support of the clinical training function of the residents at the hospital. The provisions of 42 CFR 405.421 are the governing regulations for the reimbursement of approved educational activities under the Medicare Program. Paragraph (b) of 42 CFR 405.421 defines approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities would include graduate medical education programs associated with approved

residency programs. Under the regulations, direct medical education costs are excluded from the definition of operating costs and, accordingly, are not included in the calculation of payment rates under the prospective payment system for inpatient hospital services. Therefore, medical education costs are separately identified and "passed-through" on a reasonable cost basis.

The Board finds that the medical education costs incurred for the Provider's GME programs were reasonable costs which are reimbursable under 42 CFR 405.451 and also meet the specific reimbursement requirements established under 42 CFR 405.421. In accordance with the provisions of 42 CFR 405.451, a provider of services is entitled to reimbursement of its reasonable costs incurred in the provision of patient care services. Reasonable cost includes necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. In addition, reasonable cost must be determined in accordance with other regulations establishing the methods to be used and items to be included. The provisions of 42 CFR 405.421(g) specify that the allowable cost of approved educational activities is net cost determined by deducting tuition revenues from a provider's total cost of the activities. The regulation describes a provider's total costs to include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles of 42 CFR 405.453. The cost-finding principles of 42 CFR 405.453 require the maintenance of adequate cost information which is accurate and in sufficient detail to accomplish the purposes for which it is intended, and that the data be capable of verification by qualified auditors. Through the cost-finding process, the costs of the various types of services rendered are determined by the identification of direct costs and the proration of indirect costs.

The cost study performed by the Provider complied with the full costing requirements of the regulations by identifying the total allowable costs associated with the GME programs, including direct and indirect costs. Based on the record (Provider Exhibit 3 and Appendices I and Ia) and the testimony of the Provider's expert witness (see especially Board's examination, Transcript—June 19, 1989, pages 188-218), the Board finds the Provider's cost study to be valid and acceptable. The PAR system, upon which the cost study is based, historically has been used as the basis for determining the percentage of faculty time spent in relation to GME activities and is the same system that the Intermediary audited and found to be reliable in prior cost reporting periods. Furthermore, during a field audit review, the Intermediary's auditors traced and verified the cost study to source records with only very minor discrepancies. (Provider Group Exhibit 5, at I-B). Additionally, the auditors found the cost study methods were consistent with the internal funding method, just far more comprehensive. Id.

The Board does not accept the Intermediary's argument that the Provider is shifting costs from the Medical School in violation of the community support and redistribution principle set forth in 42 CFR 405.421(c). The record shows that, historically, the Provider has always utilized the services of the faculty members of its related Medical School for the supervision and education of the residents in its GME programs. Throughout its participation in the Medicare program, the Provider has claimed the costs identified with these educational activities, and there is no evidence that the Intermediary ever disallowed the amounts claimed prior to the year in contention for this appeal. In 1985, the Provider performed an in-depth study of its GME programs in order to identify all costs related to these ongoing activities. The fact that the Provider did not fully identify all of the costs associated with its GME programs in prior years does not prohibit

the correction of this error in the cost reporting period in contention.

The Provider's refinement of its methodology for determining GME costs is permissible under the provisions of 42 CFR 405.421. The regulations at 42 CFR 405.421(c) state the following:

> . . . Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The term "redistribution" has not been defined in the regulations or other program instructions. However, the use of the term in the regulation is prefaced by the program's intent to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations. In the absence of further clarification, the Board concurs with the Provider's interpretation that the focus of the regulation with respect to redistribution is on educational "activities," and not the "cost" associated with the activity. Accordingly, the concept of redistribution would not apply unless the educational program was a new activity being performed by the provider. In this case, the Provider is merely claiming additional support costs for the GME programs it has historically operated utilizing the services of the related Medical School's faculty. The refinement of costs associated with these educational activities does not constitute a redistribution of costs from the educational unit to the patient care unit.

Moreover, the types of costs identified and the methodology employed under the Provider's cost study are expressly covered in IL 78-7, the program instructions specifically issued for determining the allowable faculty costs of a related medical school. Thus, IL 78-7 implies that

medical school support items can be included in the cost determination without effecting a redistribution. Accordingly, the Board believes that the instructions in IL 78-7 support its conclusion that reimbursement of the costs in question does not constitute a redistribution under 42 CFR 405.421(c).

The Board also finds that the Medicare program is not incurring additional costs previously borne by the community. The record shows that the only community support received by the University was appropriations from the states of Delaware and Pennsylvania. However, since the appropriated funds were specifically earmarked for the University's undergraduate Doctor of Medicine program, community support for the Provider's GME programs was not available from state appropriations (Provider's Post-Hearing Submission/Appropriation for Fiscal Year 1985). The Board also notes that the percentage of Medical School's operating costs covered by the appropriations has declined from 35 percent in fiscal year 1972 to 16 percent in 1983 (Transcript—June 19, 1989, Page 22).

DECISION:

The Intermediary's adjustments disallowing portions of the medical education costs claimed by the Provider were not proper. The Intermediary's adjustments are modified to allow the amounts of GME and physician administrative costs documented by the Provider's cost study.

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick

FOR THE BOARD:

/s/ Elise D. Smith
ELISE D. SMITH
Chairman

[Nov. 17, 1989]

APPENDIX F

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. Section 1395x(v)(1)(A)

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipient of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established

under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 C.F.R. § 413.85 Cost of educational activities.

(a) *Payment*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section. The net cost is subject to apportionment based on Medicare utilization as described in § 413.50.

* * * *

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recogized that the costs of such educational activities should be borne by

the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

* * * *

(g) *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

42 C.F.R. § 413.17 Cost to related organizations.

(a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

* * * *

APPENDIX G

Part A Intermediary Letter, No. 78-7; *Part B Intermediary Letter*, No. 78-7; Feb. 1978

We have reviewed a number of situations of medical school related teaching hospitals to evaluate the costs identified with the services rendered by faculty of the medical school (or organization related thereto) in the hospital. These situations raise questions about the reasonableness of these costs as allowable hospital costs and the appropriateness of the bases used in allocating them to the hospital.

In these situations, reasonable costs incurred by a teaching hospital for patient care services rendered by the faculty of the medical school (including organizations related to the medical school) in the hospital are allowable hospital costs provided such costs would be allowable if incurred directly by the hospital rather than under such arrangement. Reimbursement can be made to the hospital only where the costs of services rendered by the medical school faculty are charged to all components receiving services, including the hospital, on the same basis. The costs of services where the medical school and the hospital are related by common ownership or control are allowable to the hospital, providing the costs do not exceed the price of comparable services that could be purchased elsewhere and providing they are in accord with all other provisions of Chapter 10 of the *Provider Reimbursement Manual (PRM)* [¶ 5677, *et seq.*]. Reimbursement to the hospital for these costs is determined in the same manner as the costs incurred for services rendered by physicians and others on the hospital staff. Allowable costs of the medical school faculty are defined as direct salaries, applicable fringe benefits, employer's portion of FICA taxes, federal and state unemployment taxes and workmen's compensation. Allowable costs may also include the costs of other items (limited to necessary travel,

membership fees, sabbatical leave, and allowance for books) directly applicable to the services rendered by the faculty of the medical school (see attachment—Instructions for Completion of Certain Columns of "Worksheet," Column 7).

The Medicare program will recognize additional costs only if *necessary* and *directly related* to the rendition of medical school faculty services in the hospital. Generally, the only additional costs incurred in the medical school that may be allowable to the hospital relate to a medical library, physician office space and clerical support. In any situation where a hospital has its own medical library (even though less extensive than the medical school library), its own administrative structure, in any form, or provides office space or clerical support to the medical school faculty, the hospital would not be allowed to claim any such additional costs incurred in the medical school for these items. Allowable costs incurred in the medical school for items other than faculty direct salaries, applicable fringe benefits, etc., as defined above are limited to direct costs and space costs. Direct costs are limited to salaries and applicable fringe benefits of personnel directly assigned on the basis of time to the items of claimed costs (e.g., library), payroll related taxes, interest on funds borrowed to purchase movable equipment, depreciation (straight line), insurance and rent on movable equipment, and supplies. Space costs are limited to interest on funds borrowed to purchase buildings and fixtures, depreciation (straight line), insurance and rent on buildings and fixtures, taxes, operation of plant, maintenance of plant, and housekeeping. On the other hand, your attention is drawn here to any costs incurred by the hospital for the medical school which must be excluded from allowable hospital costs (e.g., the costs of meals served to medical school students).

All costs claimed by a hospital for services rendered by faculty of a related medical school and for costs incurred

in the medical school which are related to those services must be substantiated by the provider's completion of the attached "worksheet" and submitted by the provider along with its Medicare cost report. This form must be used effective with all cost reports submitted by the provider to the intermediary for cost reporting periods ending on or after December 31, 1977. Upon submission of the notice of program reimbursement by the intermediary to the provider on its cost report, the intermediary shall forward one copy of the completed "worksheet" to the address below:

Health Care Financing Administration
Medicare Bureau
Division of Provider Reimbursement
and Accounting Policy
6401 Security Boulevard
Baltimore, Maryland 21235

In addition, intermediaries should carefully scrutinize costs claimed for other than medical school faculty services which are incurred in a related medical school and allocated to the hospital. Such review must include an evaluation of the cost in terms of its allowability as being related to patient care furnished in the hospital, the reasonableness of the bases used in allocating the cost to the hospital and the reasonableness of the amount claimed. Reimbursement can be made to the hospital only where the costs of these services are charged to all components, including the hospital, on the same basis. Intermediaries should review these costs claimed on each cost report notwithstanding prior review and should seek appropriate documentation from the provider as may be necessary. This documentation should not be included on the attached "worksheet." Such costs are allowable to the hospital providing they do not exceed the price of comparable services that could be purchased elsewhere and providing they are in accord with all other provisions of Chapter 10 of the ***PRM***.

APPENDIX H

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 92-3045

OHIO STATE UNIVERSITY, d/b/a OHIO STATE HOSPITALS,
Plaintiff-Appellee,

v.

SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Defendant-Appellant.

On Appeal from the United States District Court
for the Southern District of Ohio

Decided and Filed June 8, 1993

Before: MARTIN and BOGGS, Circuit Judges; and CONTIE, Senior Circuit Judge.

MARTIN, Circuit Judge, delivered the opinion of the court, in which CONTIE, Senior Circuit Judge, joined. BOGGS, Circuit Judge, concurs in the result only.

BOYCE F. MARTIN, JR., Circuit Judge. The Ohio State University operates a 905-bed acute-care teaching hospital in Columbus, Ohio in conjunction with its medical school. The hospital, administered by the Ohio State's medical school, trains recently graduated doctors,

called interns and residents, by having them provide patient care. When Medicare was instituted, the federal government began reimbursing the hospital for medical care provided to patients by these doctors. In 1985, the hospital claimed reimbursement from Medicare in the amount of $765,000 for indirect costs only, which were the overhead costs of its graduate medical program for the provision of patient services. Included in that total was the cost of space, salaries, utilities, supplies, etc. which were related to patient services.

A Medicare intermediary, an entity hired by the Department of Health and Human Services to review cost-reimbursement applications, rejected the hospital's request for reimbursement of indirect costs. Another entity, the Provider Reimbursement Review Board, reversed this decision. Another review followed, and the Deputy Administrator of the Health Care Financing Administration of the Department of Health and Human Services reversed the Review Board's decision, agreeing with the intemediary. Review of the Deputy Administrator's denial of reimbursement was made to the federal district court. The district court granted summary judgment for the hospital, concluding that it was entitled to reimbursement of its costs related to patient care under Medicare. We agree with the district court and affirm.

A resolution of the question before us turns on the interpretation of 42 C.F.R. § 413.85. We are thus again sent into the sea of murky precedents to divine our power to overturn an agency's interpretation of its own regulations.[1] As we read *Whiteside v. Secretary of Health*

[1] Quite frankly, the degree to which courts are bound by agency interpretations of law has been like quicksand. The standard has been constantly shifting, steadily sinking, and, from the perspective of the intermediate appellate courts, frustrating. At first, agency interpretations of law were to be reviewed *de novo*. *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944) (". . . interpretations and opinions of the Administrator . . . while not controlling upon the

& Human Svcs., 834 F.2d 1289, 1292 (6th Cir. 1987), we are bound by an agency's interpretation of its own regulations unless its interpretation is not "reasonable, consistent, and persuasive." In this case, the Secretary's interpretation of 42 C.F.R. § 413.85 is neither reasonable nor persuasive.

As we read the statute, 42 U.S.C. § 1395hh, the Medicare program is designed to reimburse certain reasonable and necessary medical expenses. Educational activities,

courts by reason of their authority, do constitute a body of experience and informed judgment. . . .") However, we have been told to give "some deference" to the interpretation of the agency. *FTC v. Indiana Fed. of Dentists*, 476 U.S. 447, 454 (1986) ("The legal issues presented . . . are . . . for the courts to resolve, although even in considering such issues the courts are to give some deference to the [agency's interpretation].") And we have been told that we are not to follow an agency's interpretation if the agency's interpretation violates the specific language of the law. *Demarest v. Manspeaker*, 112 L. Ed.2d 616 (1991) ("But administrative interpretation of a statute contrary to language as plain as we find here is not entitled to deference."). Finally, we have been told that we are not to overturn an agency's interpretation of law if the agency's interpretation is "reasonable." *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., et al.*, 467 U.S. 837, 845 (1984) (Intermediate court is to determine whether agency's view "is a reasonable one."); *Whiteside v. Secretary of Health & Human Svcs.*, 834 F.2d 1289, 1292 (6th Cir. 1987) (The question for the court is "whether the Secretary's interpretation is reasonable, consistent, and persuasive.")

As we noted in *Whiteside*, 834 F.2d at 1292, an agency's interpretation of the law binds this court when the interpretation is "reasonable, consistent, and persuasive." Of course, no court has stated how to determine which interpretations of a statute are "reasonable, consistent, and persuasive" and which are not. So, after all these years of debate and after much judicial ink has been spilled, we are back to essentially the old rule that courts are not bound by agency interpretations and that courts are to apply laws based on the court's interpretation of the law's reasonable meaning. This entire process, travelling far without going anywhere, could have been avoided if the executive branch were left to enforce the law and the judicial branch were left to interpret the law.

according to 42 C.F.R. § 413.85, are reimbursable, as reasonable and necessary medical expenses if they are: 1) approved programs; 2) contribute to the quality of patient care within a hospital which receives Medicare; and 3) do not redistribute costs from educational institutions to patient care institutions. This issue was resolved precisely in *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1210 (6th Cir. 1989). In the present case, as in the *University of Cincinnati* case, the graduate medical program was accredited and contributed to patient care in the university-run hospital. The Deputy Administrator in this case, however, determined that the Hospital's request for reimbursement for certain overhead expenses constituted an unlawful redistribution of costs from the graduate program to the hospital.

In our opinion, the Deputy Administrator's decision was based on an unreasonable and unpersuasive interpretation of 42 C.F.R. § 413.85(c). That regulation provides,

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The request for reimbursement for indirect costs, known as overhead expenses outside of government, of its graduate medical program does not constitute a redistribution of costs from the medical program to the hospital. The Department interprets the "redistribution" clause of 42 C.F.R. § 413.85 to mean that costs for patient care, at one time paid by educational institutions but subsequently paid by hospitals, are not reimbursable. The Department's interpretation is neither reasonable nor persuasive because it does not comport with the language of 42 C.F.R. § 413.85(c). The language "educational activi-

ties customarily or traditionally carried on by providers in conjunction with their operations" indicates redistribution of kinds of costs, not a temporal redistribution of educational costs. The redistribution clause, therefore, applies to a redistribution of costs from an educational program, such as classroom expenses, to a provider of Medicare medical services. The graduate medical program here does not involve classroom-type expenses, but involves expenses of doctors who are furthering their training by providing medical services. As the district court noted, in finding for Ohio State University,

> [T]he plain meaning of [42 C.F.R. § 413.85(c)] is to authorize reimbursement of all direct and indirect costs related to the kinds of educational activities customarily or traditionally carried on by providers, but to deny reimbursement for costs related to educational activities which are customarily or traditionally carried on by educational institutions, such as medical and nursing schools. The court concludes that the underlying purpose of the redistribution principle is to limit reimbursement to educational costs related to patient care and to deny reimbursement for educational costs unrelated to patient care.

Contrary to the Secretary's interpretation, the district court's interpretation of 42 C.F.R. § 413.85(c) is certainly reasonable and persuasive.

The costs claimed by the hospital are not a redistribution of educational costs unrelated to patient care. They are a cost of providing patient care and are reimbursable under 42 U.S.C. § 1395hh and 42 C.F.R. § 413.85(g), which allow recovery of costs of providers of medical services relating to patient care.

The judgment of the district court is affirmed.

Judge Boggs concurs in the result only.

No. 93-120

In the Supreme Court of the United States

OCTOBER TERM, 1993

THOMAS JEFFERSON UNIVERSITY, d/b/a
THOMAS JEFFERSON UNIVERSITY HOSPITAL,
PETITIONER

v.

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE RESPONDENT

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16 pp

QUESTION PRESENTED

Under Medicare regulations, the cost of training programs for interns and residents (known as graduate medical education, or GME, programs) is an "allowable cost" for which a hospital may receive reimbursement. 42 C.F.R. 413.85(a). Reimbursement is not available, however, for any "increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." 42 C.F.R. 413.85(c).

The question presented is:

Whether the Secretary reasonably determined that 42 C.F.R. 413.85(c) bars a hospital providing Medicare services from obtaining reimbursement of otherwise reimbursable GME program costs that previously were absorbed by its affiliated medical school.

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DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The judgment order of the court of appeals (Pet. App. 1a-2a) is unpublished, but the decision is noted at 993 F.2d 879 (Table). The opinion of the district court (Pet. App. 3a-25a) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 1a-2a) was entered on April 21, 1993. The petition for a writ of certiorari was filed on July 20, 1993. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. This case involves the application of a regulation denying Medicare reimbursement to patient care institutions, such as hospitals, of "redistribute[d] costs" that are incurred in connection with a hospital's graduate medical education (GME) program. Pet. App. 10a. The question is whether the Secretary of Health and Human Services reasonably interpreted the regulation as barring reimbursement to a hospital of GME related costs that in previous years had been absorbed by the hospital's affiliated medical school, but are now being claimed by the hospital for reimbursement under Medicare.

2. In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for inpatient hospital and related post-hospital services.[1] From 1966 through 1982, "provider[s] of services" under Part A generally were reimbursed for reasonable and necessary direct and indirect costs related to Medicare-covered patient care. Pet. App. 5a. The reasonable cost calculation generally was based on the "cost[s] actually incurred," as long as the services were necessary. 42 U.S.C. 1395x(v). The Secretary was authorized to issue regulations defining the reimbursement due under this statutory standard. 42 U.S.C. 1395hh, 1395x(v)(1)(A).

[1] Part B is a voluntary supplementary insurance program covering physicians' charges and other medical services. 42 U.S.C. 1395k, 1395*l*, and 1395x(s).

Under the Medicare regulations, the costs of certain educational programs for health professional trainees, including programs for interns and residents known as graduate medical education (GME) programs, are "allowable cost[s]" for which a hospital may receive reimbursement under Medicare Part A. 42 C.F.R. 413.85(a). See also *Ohio State University* v. *Secretary, United States Dep't of Health & Human Services*, 996 F.2d 122, 124 (6th Cir. 1993), *reprinted at* Pet. App. 67a-70a. This category of reimbursable costs includes indirect and overhead costs, and it encompasses expenses directly incurred by a hospital's affiliated medical school in connection with the hospital's GME program for trainees who provide patient care services in the hospital. 42 C.F.R. 413.85(b).[2] Under the Secretary's regulations, GME costs are reimbursable only if they do not represent costs that have been redistributed from educational to patient care institutions. 42 C.F.R. 413.85(c).[3]

[2] For example, the amounts in dispute in this case included salaries, fringe benefits, and the costs of office space and support services for medical school faculty who were housed in and employed directly by the medical school and who participated in the teaching and training of in-hospital trainees. In addition, the hospital attempted to charge Medicare for expenses incurred by the medical school in connection with the admissions and general management of the GME program. Pet. App. 4a n.1.

[3] 42 C.F.R. 413.85(c) provides, in pertinent part:

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers * * * , it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

In 1983, Congress changed the method of calculating reimbursement by instituting the Prospective Payment System (PPS), which establishes fixed payment rates for various services associated with the inpatient care of program beneficiaries. See Pet. App. 5a. Costs incurred in connection with GME programs were excluded from the PPS scheme and continued to be reimbursed under the old "reasonable cost" system. *Id.* at 5a-6a. In 1986, however, Congress did make a change in the method for reimbursing GME costs by providing that, subject to appropriate updating, the calculation of GME costs to be reimbursed in all subsequent years would be based on the amount of GME costs claimed by the provider for a fiscal year that begins between October 1, 1983 and September 30, 1984 (the base year). 42 U.S.C. 1395ww(h); 42 C.F.R. 413.86(e)(1)(A) (1991).

3. Thomas Jefferson Hospital (the Hospital) is a teaching hospital operated by petitioner, a private not-for-profit educational institution. Pet. App. 8a. The Hospital operates Medicare-approved GME programs for interns and residents. The GME programs are conducted in the Hospital by faculty of petitioner's College of Medicine (the Medical School). *Ibid.*

Since 1974, the Hospital has claimed and received reimbursement for certain categories of costs related to the GME programs. Pet. App. 8a. When the PPS was implemented in 1984, the Hospital reviewed its claims for GME costs to determine whether there were any allowable costs it had not previously claimed. *Id.* at 9a. The Hospital then commissioned a formal cost study on which to base the claim for reimbursement for its 1985 fiscal year. *Ibid.* Anticipating the results of the not-yet-completed study, the Hospital increased its claim for resident and intern costs by $4,000,000 and claimed an additional $2,032,380 in indirect costs that were incurred by the Medical School in connection with its role in administering the Hospital's GME programs. *Id.* at 9a-10a.

4. The fiscal intermediary responsible for determining the Hospital's allowable costs denied reimbursement for most of the new GME-related costs that were claimed by the Hospital for its 1985 fiscal year. Pet. App. 10a. The intermediary explained that the Hospital's claims for reimbursement for the previously unclaimed expenses incurred by the Medical School in connection with the GME programs represented "an improper attempt to redistribute costs from an educational unit to a hospital unit in violation of 42 C.F.R. § 413.85." *Ibid.*

5. On appeal, the Provider Reimbursement Review Board (PRRB) reversed the intermediary's decision and allowed reimbursement of the full costs shown in the cost study. Pet. App. 11a. But the Acting Administrator of the Health Care Financing Administration (on behalf of the Secretary) then modified the PRRB's decision, deciding that the Hospital could receive payment only for "medical education costs which it had traditionally * * * been allowed prior to 1984." *Ibid.*

6. The district court sustained the Secretary's decision. Pet. App. 3a-25a. Adopting a "plain meaning" approach to the anti-redistribution regulation, 42 C.F.R. 413.85(c), the court concluded that reimbursement is available only for "costs associated with the [hospital's GME] program" that "have not been redistributed from an educational institution to a patient care unit." Pet. App. 15a. The court explained

that the regulation's language "evidences Congress' express intent" that the community should bear the costs of medical education programs and that Medicare would "participate appropriately in the support of these activities" only "*until* [] communities undertake to bear these costs." *Id.* at 20a. The court further explained that any interpretation that results in the shifting to the Medicare program of costs traditionally borne by another source—including an educational institution such as a medical school—"would plainly" contradict the purpose of the 1983 revisions of the Social Security Act, which was to "stem[] the spiraling costs of the Medicare program to prevent exhaustion of the fund and achieving a level of budget neutrality." *Ibid.* The court noted that "[i]t is uncontroverted that the excess costs claimed by the Hospital in fiscal year 1985 previously were borne by the Medical School." *Id.* at 22a. The court therefore agreed with the Secretary's conclusion "that the increased claim for reimbursement represents an impermissible redistribution of costs from an educational institution, the Medical School, to a patient care institution, the Hospital." *Ibid.*

The district court rejected, as "in conflict with the plain language of the regulation," the Hospital's argument that the community support and redistribution principles should apply "only to the academic or 'classroom' portions of the Hospital's training programs and not to clinical training programs." Pet. App. 16a. After noting that the training of interns and residents "is predominantly, if not exclusively, clinical in nature," the court stated that "[t]he regulation simply contains no language evidencing an intent to distinguish between academic and clinical

training for purposes of the allowability of the costs claimed." *Id.* at 16a-17a.

7. The court of appeals affirmed without opinion. Pet. App. 1a-2a.

ARGUMENT

The court of appeals, affirming the judgment of the district court, correctly sustained the Secretary's interpretation of the anti-redistribution regulation to deny reimbursement to the Hospital for GME-related costs that had been absorbed by its affiliated medical school in previous years. We nevertheless agree with petitioner that the Court should grant certiorari in this case. The decision below is in conflict with a recent decision of the Sixth Circuit, see *Ohio State University* v. *Secretary, United States Dep't of Health & Human Services*, 996 F.2d 122 (1993), and the question presented is of sufficient importance to warrant this Court's review.

1. The anti-redistribution regulation, 42 C.F.R. 413.85(c), states that costs associated with GME programs in patient care units should ordinarily "be borne by the community," rather than by Medicare. The regulation states, however, that the Medicare program will "participate appropriately in the support of these activities" for communities that have not "assumed responsibility for financing these programs." The regulation goes on to state, however, that "it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." 42 C.F.R. 413.85(c).

The Secretary interprets the regulation as establishing a distinction between cases in which no entity

in the "community" has undertaken to absorb the costs of medical training programs associated with patient care, and those in which an "educational institution[]"—such as the Medical School in this case—has previously absorbed costs that could otherwise have been (but were not) claimed by the affiliated provider under Medicare. 42 C.F.R. 413.85(c). In the latter case, the payment of Medicare reimbursement for educational program costs that had previously been absorbed by the medical school would constitute a "redistribution of costs" from an educational unit to a patient care institution, in violation of the plain terms of the regulation. *Ibid.*

The district court agreed with the Secretary's conclusion that the regulation "admits of only one interpretation, to wit, if the costs of activities customarily and traditionally carried on by providers in conjunction with their operations have been absorbed by an educational unit, such costs may not later be redistributed to a patient care unit." Pet. App. 21a-22a. Since it is "uncontroverted" in this case that "the excess [GME-related] costs claimed by the Hospital in fiscal year 1985 previously were borne by the Medical School," *id.* at 22a, the court of appeals was correct to affirm the district court's holding that the Hospital was barred under the regulation from receiving Medicare reimbursement for the excess costs at issue.

Even if more than one interpretation of the regulation were possible, however, the result in this case is still correct, because the Secretary's construction of the regulation is, at the very least, reasonable. The Secretary has an explicit mandate to formulate regulations to define what reimbursement is due

under the "reasonable costs" standard. 42 U.S.C. 1395hh, 1395x(v)(1)(A); see *Good Samaritan Hosp.* v. *Shalala*, 113 S. Ct. 2151, 2158 (1993). Given that mandate, it is axiomatic that the agency must be accorded broad discretion in interpreting and applying its implementing regulation. See *Udall* v. *Tallman*, 380 U.S. 1, 16-17 (1965) (an agency's interpretation of its own regulation must be given "controlling weight unless it is plainly erroneous or inconsistent with the regulation"); *Robertson* v. *Methow Valley Citizens Council*, 490 U.S. 332, 359 (1989) (same); *Martin* v. *OSHRC*, 111 S. Ct. 1171, 1175-1176 (1991). See also *University of Cincinnati* v. *Heckler*, 733 F.2d 1171, 1173-1174 (6th Cir. 1984) (deference should be accorded "especially in areas like Medicare reimbursements"); *Butler County Memorial Hosp.* v. *Heckler*, 780 F.2d 352, 356 (3d Cir. 1985); *Abbott-Northwestern Hosp., Inc.* v. *Schweiker*, 698 F.2d 336, 340 (8th Cir. 1983); *Cheshire Hosp.* v. *New Hampshire-Vermont. Hosp. Serv.*, 689 F.2d 1112, 1117 (1st Cir. 1982).[4]

2. Although the decision of the court of appeals is correct, we agree with petitioner that the Court should grant certiorari in this case. The court of appeals' decision conflicts with the Sixth Circuit's recent decision in *Ohio State University* v. *Secre-*

[4] Contrary to petitioner'ssuggestion (Pet. 15-16), the Secretary's recent proposal to amend 42 C.F.R. 413.85 to include a definition of the phrase "redistribution of costs" as it appears in Section 413.85(c), see 57 Fed. Reg. 43,660, 43,672 (1992), effects no change in the meaning or operation of the regulation. On the contrary, as stated in the preamble to the proposed amendment, its purpose is to "restate or clarify our current policies governing these costs." *Id.* at 43,660.

tary, United States Dep't of Health & Human Services, 996 F.2d 122 (1993). In that case, a teaching hospital affiliated with a university medical school sought Medicare reimbursement for expenses incurred in 1985 for the operation of its GME training programs. The Sixth Circuit held that even where the disputed GME costs previously had been borne by the medical school, reimbursement for those costs would not violate the prohibition on redistribution in 42 C.F.R. 413.85(c) as long as the costs were related to patient care. 996 F.2d at 124. The court construed the proscription against redistribution as not applying to "educational activities customarily or traditionally carried on by providers in conjunction with" patient care activities, but as covering only "redistribution of costs from an educational program, such as classroom expenses, to a provider of Medicare medical services." *Ibid.* Because the Sixth Circuit ordered Medicare reimbursement for GME expenses that had not previously been claimed by the Medicare provider, the decision in *Ohio State* directly conflicts with the decision in the instant case.[5]

Furthermore, the proper interpretation of the Secretary's anti-redistribution regulation presents an important and recurring issue that has a major fiscal impact on the administration of the Medicare program. According to the Department of Health and Human Services, at least ten university teaching hospitals have filed claims for Medicare reimburse-

[5] The Solicitor General accordingly has determined that a petition for a writ of certiorari will be filed in *Ohio State*, with the suggestion that the petition be held pending disposition of this case. The certiorari petition in *Ohio State* is due on November 2, 1993.

ment for GME program-related costs incurred in their base year[6] and in later years. Claims for more than $116 million for services provided from 1985 through the early 1990's by seven teaching hospitals are currently pending before the Provider Reimbursement Review Board. Each of those institutions could have additional unaudited claims for more recent periods. In addition, approximately $29 million in claims are at issue in cases already decided by, or pending, before the courts of appeals, including $3.5 million in this case for services provided through 1989, and $6 million in *Ohio State* for services provided through 1991.[7] Finally, HHS has determined that there are between 15 and 20 more university-affiliated patient care institutions that would be eligible to submit additional claims for GME-related expenses incurred in their base year and in subsequent years. In sum, resolution of the legal issue in this case is important because it will determine the disposition of pending Medicare

[6] As explained above, Congress in 1986 changed the method for reimbursing GME costs by providing that, subject to appropriate updating, the calculation of GME costs to be reimbursed in all subsequent years would be based on the amount of GME costs claimed by the provider for its fiscal year beginning between October 1, 1983 and September 30, 1984 (the base year). 42 U.S.C. 1395ww(h).

[7] Medicare claims totalling approximately $19 million for GME services provided by a teaching hospital affiliated with the University of Minnesota from 1985 through 1990 are potentially at issue in *Board of Regents of The University of Minnesota* v. *Shalala*, appeal pending, No. 93-2420 (8th Cir.), which presents the same question of the interpretation and application of the anti-redistribution regulation that is at issue in this case.

reimbursement claims involving, to date, $150 million dollars and will have a continuing and substantial impact on future claims.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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OCTOBER 1993

No. 93-120

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

THOMAS JEFFERSON UNIVERSITY
d/b/a Thomas Jefferson University Hospital,
Petitioner,

v.

DONNA E. SHALALA, SECRETARY
Department of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS FOR
THE THIRD CIRCUIT

JOINT APPENDIX

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Certiorari granted January 10, 1994

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CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

I. U.S. DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Thomas Jefferson University d/b/a Thomas Jefferson University Hospital v. Louis W. Sullivan, M.D., Secretary of Health and Human Services, No. 90-CV-2036, Judge William H. Yohn, Jr., filed March 23, 1990.

DATE	DESCRIPTION
3/23/90	Complaint.
6/6/90	Answer of Defendant.
12/12/90	Motion by Plaintiff Thomas Jefferson For Leave To File Amended and Supplemental Complaint, Memorandum in Support (Complaint attached).
1/9/91	Order that Plaintiff shall have leave to file an amended and supplemental Complaint within 10 Days, etc.
1/14/91	Answer to amended and supplemental Complaint by Defendant Louis Sullivan [Entry date 1/15/91].
4/19/91	Praecipe by Defendant Louis Sullivan to file attached administrative transcript [Entry date 4/22/91].
8/16/91	Motion by Defendant Louis Sullivan for Summary Judgment, Memorandum in Support.
8/19/91	Motion by Plaintiff Thomas Jefferson for Summary Judgment, Memorandum in Support.

DATE	DESCRIPTION
9/18/91	Reply by Defendant Louis Sullivan to Plaintiff's Cross-Motion for Summary Judgment [Entry date 9/19/91].
9/18/91	Response by Plaintiff Thomas Jefferson in Opposition to Defendant's Motion for Summary Judgment [Entry date 9/19/91].
4/27/92	Stipulation and Order that the Secretary will instruct the fiscal intermediary, AETNA, to calculate amounts due, and pay those amounts to Thomas Jefferson within 90 days, etc. Plaintiff agrees to a dismissal of its cause of action seeking reimbursement for the costs, etc. Nothing in this agreement shall preclude Plaintiff from bringing an action before the Court for breach of this agreement or to enforce the terms of this agreement, etc. [Entry date 4/28/92].
5/1/92	Memorandum and Order that Plaintiff shall submit within 10 days an affidavit setting forth the date upon which the Final Decision of the Secretary denying reimbursement of certain costs claimed by the Hospital for Fiscal Year 1985 was received; Plaintiff's Motion for Summary Judgment is denied; Defendant's Motion for Summary Judgment is granted; Judgment is entered for Defendant and this case shall be marked as Closed. (Signed by Judge William H. Yohn Jr. on 5/4/92) [Entry date 5/4/92].

DATE	DESCRIPTION
6/22/92	Notice of Appeal by Plaintiff Thomas Jefferson Copies to Judge William H. Yohn Jr., Clerk USCA, Appeals Clerk, and David F. McComb, Michael M. Baylson, Linda A. Ruiz, Dona S. Kahn, Joel Tornari [Entry date 6/23/92] [Edit date 6/23/92].
6/22/92	Copy of Clerk's Notice to USCA re Appeal [Entry date 6/23/92].
7/21/92	Transcript for Oral Argument Before Judge William H. Yohn, Jr. on 4/10/92 [Entry date 7/22/92].
7/22/92	RECORD COMPLETE FOR PURPOSES OF APPEAL.

II. U.S. COURT OF APPEALS FOR THE THIRD CIRCUIT

Thomas Jefferson University d/b/a Thomas Jefferson University Hospital v. Louis W. Sullivan, M.D., Secretary of Health and Human Services, No. 92-1513

DATE	DESCRIPTION
6/24/92	Civil Case docketed. Notice filed by Thomas Jefferson.
7/23/92	Certified List filed.
9/1/92	Brief of Appellant Thomas Jefferson.
9/1/92	Appendix of Appellant Thomas Jefferson.
10/13/92	Brief of Appellee Secretary HHS.
10/16/92	Motion filed by Appellee to file supplemental Appendix.

DATE	DESCRIPTION
10/22/92	Order (Clerk) granting motion to file supplemental Appendix by Appellee with filing as of the date of this Order.
10/22/92	Appendix of Appellee Secretary HHS.
10/29/92	Reply Brief of Appellant Thomas Jefferson.
10/29/92	Supplemental Appendix of Appellant Thomas Jefferson.
11/20/92	Motion of Appellee to file response to new material in Appellant's Reply Brief.
11/20/92	Response by Appellee to new material in Appellant's Reply Brief.
4/21/93	Judgment-Order (Mansmann, Authoring Judge, and Alito and Aldisert, Circuit Judges) Affirmed. Costs taxed against Appellant.
7/30/93	U.S. Supreme Court Notice filed advising Petition for Writ of Certiorari filed by Appellant Thomas Jefferson. Filed in the Supreme Court on 7/20/93, Supreme Court case number: 93-120.
1/14/94	U.S. Supreme Court Order, dated 1/10/94, granting Petition for Writ of Certiorari by Appellant Thomas Jefferson.
1/31/94	Letter dated 1/26/94 from U.S. Supreme Court Clerk requesting that we certify and transmit the entire record to their Court.
2/2/94	Certified copy of briefs, appendices and partial proceedings in this Court sent to U.S. Supreme Court Clerk.

TESTIMONY OF MARK L. RICHARDS

TESTIMONY OF ARTHUR G. BOLL

June 19, 1989
Before the Provider Reimbursement Review Board

Thomas Jefferson University Hospital

v.

AETNA Life Insurance Company
Case No. 86-1588

Appearances:

McDermott, Will & Emery, Chicago, Illinois,
By: James M. Gaynor, Jr. and Mary Zerega,
for Thomas Jefferson University Hospital

AETNA, By: Paul R. Gulbrandson, for AETNA.

MARK L. RICHARDS, having been called as a witness on behalf of Thomas Jefferson University Hospital, being first duly sworn, testified on his oath as follows:

DIRECT EXAMINATION

BY MS. ZEREGA:

[142][1] Q. Did you do any further re-evaluation of your costs claiming — 1985?

[1] For the convenience of the Court, we have provided a citation to the A.R. page rather than the court reporter's transcript page.

[143] A. Yes we did. At the insistence of the dean and the medical school in terms of their unwillingness to continue to support graduate medical education in the hospital we engaged the firm of Touche, Ross to evaluate what costs were actually being incurred by the hospital — or correction by the medical school on behalf of the hospital for graduate medical education.

Also, the clerical costs claimed in 1984 were not the — as well documented as we would have liked and this study would also in fact clarify and solidify the costs that were being claimed for clerical costs.

Q. Were the results of that cost study used as the basis for the Provider's 1985 reimbursement — ?

A. Yes they were. The cost study — we agreed to get the cost study in February of 1985. The fiscal year closed June 30th, 1985 and the actual meat of the study did not begin until the summer of 1985 since it would be required that the books of the medical school and the hospital be closed after the fiscal year for them to begin serious work on this undertaking.

Q. So the cost study — was the cost study completed at the time that the cost report was submitted in 1985?

A. No it was not. The actually [sic] cost study performed by Touche, Ross was still under way at the [144] time of the cost report filing and as a result the Provider booked an A-8 adjustment to the cost report to reflect additional costs which might be documented by Touche, Ross.

Q. What was different about the costs claimed in '85?

A. The costs claimed in 1985 aside from the typical costs claimed by the hospital which included salaries, fringe benefits of the faculty and clerical costs included some other items which had not been previously claimed but were documented by the Touche, Ross study. These costs included non-salary costs incurred by the medical school, depreciation and space costs of the medical school related to graduate medical education and also overhead costs incurred by the medical school related to graduate medical education. All documented by the Touche, Ross study.

* * * *

CROSS EXAMINATION

BY MR. GULBRANDSON:

[192] A. Which exhibit is that please?

Q. I-13. Would you look at page 3 of that letter.

A. Yes.

Q. Would you tell me what the intent of that little chart that there's all those numbers of there is?

A. The numbers as a whole reflect those costs that could be supported by the hospital as graduate medical education costs.

Q. Are these increase costs that the hospital will be claiming?

A. That is correct.

Q. And therefore the share born [sic] by the medical school will be decreased?

A. In some case, yes.

Q. I don't suppose you'd call that a redistribution?

A. No I would not.

Q. When were these costs identified?

A. Well I'm not exactly sure when they were identified but I believe it was probably an estimate by Mr. Boll at some point during the summer and based upon initial assessments.

* * * *

EXAMINATION BY THE PRRB

MR. OWENS:

[205] The intermediary believes that a redistribution occurred. You believe it does not. Could you tell us why you believe it does not?

A. I believe that the cost over the years for graduate medical education have increased significantly and that the hospital has not kept up the pace of the increasing costs of graduate medical education. If the hospital funded to the medical school back in 1973, one million dollars I think it would be extremely unrealistic to expect the same amount of money, one million dollars, to be funded in 1985. Obviously, there is a growth of expenditures here and in fact the hospital has had

a huge growth in the residency programs as well as in the number of full-time faculty. As a result of this growth and this [206] full-time faculty and in the number of residents associated with the hospital there has been portionate [sic] increases in graduate medical education costs and it's something that we believe that the hospital should be paying for. So there has been a substantial growth in graduate medical education costs over the years and also the fact that the medical school is getting more and more squeezed since these costs are now being borne by the medical school.

* * * *

MR. OWENS:

[207] Were those elements components that you'd also recognized in previous years? I want to make [208] sure I understand.

A. Yes they were and again the pure professorial salary run which includes the physician's activity reports and nothing additional. No clerical costs, no overhead or anything else.

MR. OWENS:

Now the Touche Ross study dwells more upon new components that you hadn't utilized before?

A. Yes. The Touche Ross study examined other areas which the Dean believed, he was incurring significant costs for, mainly in the area of non-salary costs.

MR. OWENS:

Space,

A. Yeah space, overhead and so forth. In addition, clerical costs were also fully documented in the '85 year.

MR. OWENS:

Now once again the bottom line on '86 was accepted in full by the intermediary?

A. Yes.

MR. OWENS:

With any question?

A. That is correct.

MR. OWENS:

And one last question. The Touche Ross injection of components that had previously been unrecognized in your cost report, that is not regarded by the provider as redistribution either is that correct?

A. No it is not and it reflects the growth over time, substantial costs incurred by the medical school which at one point back in '73, '74 or '75 may have been [209] inconsequential and not of serious consideration for our consideration to be funded by the hospital.

* * * *

MR. BRAGONZA:

In 1984 which entity bore the non-salary costs, the space costs and the complete clerical costs?

A. The medical school. Now the hospital bore the professorial salary costs and clerical costs.

MR. BRAGONZA:

I'm talking about the non-salary costs and the space costs?

A. The medical school.

MR. BRAGONZA:

In 1984 the medical school bore those costs?

A. That's correct.

MR. BRAGONZA:

In 1985, you're claiming then it was the hospital.

A. Yes that's correct.

MR. BRAGONZA:

Isn't that a redistribution of costs?

A. No. I believe it's a growth of costs that should be recognized by the hospital that incurred by the medical [210] school over time and at one point were inconsequential.

MR. BRAGONZA:

In 1984 were they inconsequential?

A. No. That's why the Dean was screaming at the hospital to support these costs.

MR. BRAGONZA:

They weren't inconsequential in 1984?

A. No they were not.

MR. BRAGONZA:

Who bore them in '84?

A. Medical school.

MR. BRAGONZA:

So there was at least a transfer if not a redistribution, call it what you will, in 1984 the medical school bore some costs that were not inconsequential and in 1985 the hospital is bearing them, claiming them?

A. That is correct.

MR. BRAGONZA:

In your opinion that's not a redistribution?

A. No it's not.

* * * *

CHAIRWOMAN SMITH:

[215] So what you're saying is that you believe that Medicare should bear some of the burden of those costs because those costs are incurred in running the program that actually takes place at the hospital?

A. That is correct and in fact those secretaries could just as easily be assigned to a hospital payroll

number or part of the salary could be assigned to a hospital payroll if necessary and they could be paid directly by the hospital but we've always used this transfer mechanism in the past and had no objection from the intermediary in terms of funding these types of activities.

CHAIRWOMAN SMITH:

So what you did through the Touche Ross study was simply, well not simply, you reached out and pulled in further categories of costs or just increased costs, categories from which it had always been allowed before?

A. No. I would say that in terms of the clerical support we provided additional documentation because we had claimed that in 1984, but we did expand upon the categories of those costs claimed that we had never claimed [216] before and those included the non-salary costs, overhead, space and so forth, but the salaries and fringe benefits of the physicians and clerical costs had been claimed in the past.

CHAIRWOMAN SMITH:

I see. So the focus of the Touche Ross study was to arrive at some kind of method for breaking those out of the medical schools costs is that correct?

A. Yes it was and in order to document the amount of costs associated with graduate medical education I believe it was necessary for Touche Ross to segregate all the costs into their component parts and develop appropriate methodologies to be used to segregate those costs and develop appropriate allocations that would be acceptable basis for charging those costs to the hospital.

* * * *

ARTHUR G. BOLLS, having been called as a witness on behalf of Thomas Jefferson University Hospital, being first duly sworn, testified on his oath as follows:

DIRECT EXAMINATION

BY MR. GAYNOR:

[229] Q. And subsequent to the Thomas Jefferson [230] engagement have you done studies for other teaching institutions?

A. Yes I have. I think five other university teaching hospitals.

Q. Do you have an opinion as to whether teaching hospitals as a group have been re-evaluating their practices with respect to claiming medical school costs?

A. I have a very strong opinion. They clearly are. The reason that I think that I've been involved in studies like this is that the issue of what are the costs of graduate medical education that are benefitting the hospital or performed in the hospital environment and the level of reimbursement by the hospital to the medical schools for those services is becoming a major issues, as the hospitals, as the medical schools are coming under

increasing financial pressures. If you look at the traditional financing sources of graduate medical education they have been in the areas of essentially state appropriations, practice plan revenues, and to the extent that the hospital has paid cash reflected through charges to the payors. Those have been traditionally the three. Further complicating it is the reality that the Gramm-Rudman and other deficit reduction acts have put increasing pressures on states to reduce their support for graduate medical education. There's been a redesign and [231] greater limitations on the A21 indirect cost methodology under the federal grants. There's been changes in strategies as to how to award federal grants. All of which have continued to create financing pressures. Then you go into the whole area of Medicare as hospitals now and particularly a hospital like Thomas Jefferson has significant dependence on the practice plan contributions in order to finance the cost of graduate medical education. Those practice plans of physicians in their private practice are coming under greater financial pressures because of reimbursement reform and competition in the marketplace. So that the traditional source of the financing in the School of Medicine which incurred and paid the vast bulk of the cost of graduate medical education are now starting to go away or be undermined. The issue now becomes what is the appropriate and the most [s]table long-term financing structure for graduate medical education and if you ask the Deans, their opinion is to get those costs properly reflected on the books of the hospital

and passed them on to in terms of charges to create some stability in the financing structure.

* * * *

[236] Q. I believe your testimony was that in a number of these institutions the driving force behind re-evaluation of cost claims was the medical school?

A. That's correct.

Q. And not the hospital?

A. The hospital is a willing participant. I mean they're both related parties. They both face off to the future together. I'm not sure there can be a viable university teaching hospital without a viable medical school. They're so linked because the teaching hospitals provide the capital and facilities base and what I'll call the patient care support. The medical schools provide the programmatic initiatives in terms of physicians with leading in surgical or diagnostic capability that [237] essentially operate in the university hospital setting.

* * * *

[239] Q. Did 413.85 as it applied to Thomas Jefferson fiscal year '85, require offset of restrictive gifts?

A. No it did not because when the PPS regulations were implemented that requirement for the offset of restricted grants was taken away.

Q. So that the only offset that the regulation addresses is tuition? We've heard some discussion this morning about the question of redistribution and the language found in 413.85 sub-paragraph c. I assume you've given some consideration to that language in preparing your cost studies?

A. Yes I have. Given a lot of consideration and a lot of research.

Q. And what have you found in terms of, have you found any explications of that language in other areas of Medicare program policy, general instructions for instance?

A. Well certainly when you, if you look at the written material, the issue of redistribution was not something that was really articulated and to the best of my knowledge not applied prior to early 1985. It may have been but it certainly hasn't come under my attention prior to that. It has since then been you know discussed and I think from the regulations its not very well defined [240] exactly how it is applied. I think if we look back to the prior [PRRB] rulings and look for some applications I think it gives a general framework but specifics, the one case where it's given a specific example is where a hospital rents classroom space in support of a program occurring in the hospital and that was determined in the program manual to be okay

and not a redistribution. I mean that's about the only specific reference that it's given.

Q. So you're not aware of any discussion of redistribution principle in general instructions as such?

A. No. Subsequent there's been intermediary letters, guidance or whatever that have essentially started to define from their viewpoint what redistribution is.

* * * *

STATEMENT BY MR. GAYNOR:

[242] . . . We have produced in our exhibits a series of exchanges of correspondence between the Health Care Financing Administration, regional office, and the University of Oregon with respect to that institutions attempts to claim reimbursement for medical school costs that had not previously been claimed. This letter which the intermediary has introduced and I believe is in our exhibits as well is a kind of general discussion of the allowability of such cost claims and our only point is that as late as March 7, 1986, there is no reference to the notion of redistribution applying to a type of activity at Oregon that we are engaged in here with respect to Thomas Jefferson.

CHAIRWOMAN SMITH:

That was the point also of your including the other exchanges and the letters in your documents?

MR. GAYNOR:

Correct. Because there is no published discussion we have been able to find that we were able to obtain through discovery of the redistribution concept. The best we could do was try to find examples of situations in which HCFA approved in some fashion the kind of cost claim that Thomas Jefferson is seeking. Indirect evidence of what the agency's own view was, is of redistribution and that is,

CHAIRWOMAN SMITH:

All right. Thank you.

* * * *

[328] A. My position would be, my position is that I think Leonard gave the best example I've ever seen that says the cost was never that cost. It was a cash amount derived from historical negotiations and we need to establish what the cost is and the cost or the payment from the hospitals never kept track with the increased cost of the medical school and so we were underpaying for services that we were provided.

MR. BRAGONZA:

Through the change in methodology is resulting in costs being borne by the program that were previously borne by the school.

A. Yeah it had to be.

MR. BRAGONZA:

Had to be.

A. By definition had to be.

MR. BRAGONZA:

At least we can agree on that. They were previously borne by the school. They're not being borne by the program.

A. Well they're previously borne by the entity but yeah, okay. . . .

* * * *

MR. BRAGONZA:

[330] And that's why I have not quite the macro view that you have Mr. Boll and that's, I'm trying to struggle with it. I recognize the point you're making in that the long-term there may be a problem but I'm still trying to reconcile the facts and circumstances of this hospital with this regulation.

A. I'll still go back to my utilities case.

MR. BRAGONZA:

Thank you. I have no further questions.

CHAIRWOMAN SMITH:

I just want to understand the payment issue a little bit better. If the provider were to prevail and get reimbursement that it asked for for 19, fiscal year 1985, would that go over to the medical school?

A. I would, yeah, I mean that's my understanding.

CHAIRWOMAN SMITH:

Turn around and pay the medical school?

A. Those are the costs. Just, one of my clients, one of my university hospital medical school clients, not TJU. They're looking at programmatic and capital investment needs of 40 million dollars over the next three years. So I mean the money will be, and a lot of them say we need to make, we need to create a source for these [331] activities.

EXHIBITS FROM ADMINISTRATIVE RECORD

Excerpts of Department of Health and Human Services Memorandum from Albert J. Benz, Associate Regional Administrator in Division of Financial Operations, to Director of Office of Reimbursement Policy, dated March 29, 1982

Date: March 29, 1982

From: Associate Regional Administrator
Division of Financial Operations

Subject: Allowability of Costs Incurred by a Teaching Hospital for Services Rendered by Faculty at a Related Medical School.

To: Director, Office of Reimbursement Policy

Attached is a report, "Reimbursement for Costs Relating to Teaching Physicians—Issue Analysis," which was prepared by the Executive Consulting Group, Inc. for the University Hospital of the University of Oregon Health Sciences University. The report concludes that supervision and training is provided by University of Oregon Medical School physicians to medical students, interns, and residents in the University Hospital and that the associated costs are reimbursable under the Medicare and Medicaid programs. These costs are identified at $2.6 million. Also suggested by the report is an effort analysis methodology for the identification of these "allowable" training and supervision costs.

The report was provided to us by the hospital's intermediary, Oregon Blue Cross, who has asked for our review and determination of the allowability of the costs and the suggested methodology.

Because of the significance and potential national implication of this issue and the absence of specific guidelines in this area, we request your review of this report and policy clarification regarding the allowability of these costs. We require policy guidance in three areas: allowable activities, acceptable methodologies, and other concerns.

Allowable Activities

Chapter 400 of the Provider Reimbursement Manual contains the cost principles pertaining to the costs of educational activities; however, it does not specifically address the costs of medical school faculty providing services to a hospital. Only in Section 406 is the relationship between a medical school and a teaching hospital addressed. This section implies a prohibition against transferring medical school costs to a hospital.

> "it is not intended that this program should pay for increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units."

However, Intermediary Letter (IL) 78-7 contains policy allowing certain costs of educational institutions.

> ". . . reasonable costs incurred by a teaching hospital for patient care services rendered by the faculty of the medical school in the hospital are allowable hospital costs provided such costs would be allowable if incurred directly by the hospital rather than under such arrangement."

Unfortunately, IL 78-7 did not further define allowable faculty services. Therefore, at this point, we have concluded that certain faculty activities with regards to teaching hospitals are allowable, but we are unable to clearly define those activities. Please provide clarification of allowable faculty activities. To which patient care services does IL 78-7 refer? Are supervision and training of residents, interns, and medical students as claimed

by University Hospital allowable patient care services per IL 78-7?

* * *

Other Concerns

1. Reasonableness - As indicated, University Hospital has identified approximately $2.6 million of costs associated with training and supervision of residents, interns and medical students. Identification procedures are not precise and allowable activities apparently are not clearly defined, therefore, we see a potential that additional costs may be claimed. Can you provide us with any information upon which we and the intermediary may make a determination of the reasonableness of these costs?
2. Medical School Indirect Costs - Per IL 78-7, we have concluded that reimbursement of medical school indirect costs calculated via the medical school indirect cost rate are not allowable for transfer to the hospital along with the allowable medical school faculty costs. Is this correct?
3. Physician Compensation - Once an allowable activity has been identified, how should it be costed? What consideration should there be of the physicians' Part B reimbursement?

Please contact Robert Reed of my staff at FTS 399-1382 [if] further clarification is required.

[Signed by Albert J. Benz]

Excerpts of Health Care Financing Administration Memorandum from Bernard J. Patashnik, Director of Division of Institutional Services, to Albert J. Benz, Regional Administrator, dated May 4, 1982

May 4, 1982

Refer to: FQA-531

Division of Institutional Services
Reimbursement, Reimbursement Policy, BPP, HCFA

Allowability of Costs Incurred by a Teaching Hospital for Services Rendered by Faculty at a Related Medical School (Your Memo Dated 3/26/82)-INFORMATION

Regional Administrator
Seattle
Attention: Albert J. Benz

You requested that we review a consultant report regarding allocation of medical school costs that was prepared for the University of Oregon. You also asked for clarification of policies pertaining to three specific issues. Our comments are grouped according to those issues.

1. Allowable Activities

The allocation of costs to a hospital from a related medical school is governed by Intermediary Letter 78-7. The costs of services can be allocated to the hospital only when the services would have been allowable if the hospital had incurred the costs directly. Thus, the services must be related to the care of hospital patients and cannot be duplicative of services already available in the hospital.

The allowable provider component of physicians' services includes: supervision of residents, interns and medical students providing or assisting in providing services to hospital patients, and rounds and patient care conferences

relating to hospital patients. Non-allowable services includes: teaching formal courses, grading papers, and assisting in medical school curriculum development.

* * *

3. Other Concerns

Medical school costs being allocated to a hospital should be assessed in the same manner as any other hospital cost. The cost should be assessed in terms of the amount of services the hospital received and compared to similar costs incurred by other hospitals. As you surmised, the medical school cannot transfer indirect costs calculated via an indirect cost rate to the hospital.

We do not understand your question about how allowable activities should be costed". Total physician compensation is allocated to the various allowable and unallowable activities using an allocation methodology as discussed in item 2 above. Thus, it is merely necessary to know what portion of time is spent in the various activities. Once the costs associated with the various activities are determined in accordance with IL 78-7, the individual amounts would be included in the appropriate cost centers. Reimbursement for physicians' professional services is handled just as it would be in any other hospital-based physician situation in a teaching setting.

Bernard J. Patashnik
Director

Health and Human Services Memorandum From Linda M. Magno, Director of Division of Hospital Payment Policy, to Associate Regional Administrator of Division of Financial Operations, dated December 29, 1985

December 29, 1985

Refer To: FQA-56

Director
Division of Hospital Payment Policy, BERC

Oregon Health Sciences University—Allowability of Salary Costs of University Medical School Teaching Faculty (Your Memorandum Dated October 25, 1985)—INFORMATION

Associate Regional Administrator
Division of Financial Operations
Seattle Regional Office

This is in response to your request for clarification of our policy concerning education costs incurred by the medical school but allocated to the university hospital.

In your memorandum to us, you mentioned that a May 4, 1982, memorandum from central office stated that Intermediary Letter 78-7 governed the allocation of costs to a hospital from a related medical school. However, the central office memorandum did not specifically discuss the policy with respect to the redistribution of costs from a medical school to a hospital. The fact that this issue is not mentioned in the subject memorandum does not change the basic policy as espoused in 42 CFR 405.421(c). This section of the regulations provides that where costs for items and services were previously borne by a medical school, their allocation to a university hospital represents a redistribution of costs from an educational institution to a patient care institution. In such situations, these costs are not reimbursable under the Medicare program.

In general, educational activities conducted by a medical school related to a hospital, while enhancing the ability of interns and residents to provide quality health care services, are not directly related to the care of specific patients for whom a teaching hospital is responsible. For this reason, such activities do not meet the requirements set forth in 42 CFR 405.451. On the other hand, certain identifiable activities conducted by the faculty of a related medical school, which are necessary for the clinical training function at the hospital, *may* represent allowable costs for Medicare program purposes. These activities include supervision of interns and residents, and the conducting of rounds and patient care conferences relating to hospital patients. More specifically, services that are both related to the care and treatment of the hospital's patients and furnished in support of the clinical training of interns and residents meet the requirements for reimbursement.

Such items and services must be necessary and *directly* related to the rendition of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, those costs may be allowable that are incurred by the university medical school which can be directly related to the training program for the interns and residents working in the university hospital.

In conclusion, allowable costs that were previously borne by the medical school and allocated to the hospital represent a redistribution of costs from an educational institution to a patient care institution. Accordingly, such costs would not be reimbursable under the Medicare program. In view of this and the fact that such redistributed costs were allowed by the intermediary in settled cost reports for FYE June 30, 1982 and FYE June 30, 1983, the cost reports for these two reporting periods should be reopened and the redistributed costs disallowed.

If you have further questions regarding this matter, please contact Jack Jones of my staff at FTS 987-2884.

Linda M. Magno

Excerpts of Letter from Linda M. Magno, Director of HHS Division of Hospital Payment Policy, to David M. Witter, Jr., Interim Hospital Director at The Oregon Health Sciences University, dated March 7, 1986

Mr. David M. Witter, Jr.
Interim Hospital Director
The Oregon Health Sciences University
3181 S.W. Sam Jackson Park Road
Portland, Oregon 97201

Dear Mr. Witter:

This is in further response to your inquiry regarding Medicare reimbursement for certain teaching physician costs incurred by the Oregon Health Sciences University hospital and Medical school. You are concerned about the allowability under Medicare of certain medical school faculty costs not previously claimed by the hospital for reimbursement purposes.

In general, educational activities conducted by a medical school related to a hospital, while enhancing the ability of interns and residents to provide quality health care services, are not directly related to the care of specific patients for whom a teaching hospital is responsible. For this reason, such activities do not meet the requirements set forth in regulations at 42 CFR 405.451. On the other hand, certain identifiable activities conducted by the faculty of a related medical school, which are necessary for the clinical training function at the hospital, *may*

represent allowable costs for Medicare program purposes. These activities include supervision of interns and residents in activities for which no Part B charge is rendered, and the conducting of rounds and patient care conferences relating to hospital patients. More specifically, services that are both related to the care and treatment of the hospital's patients and furnished in support of the clinical training of interns and residents meet the requirements for reimbursement.

Such items and services must be necessary and *directly* related to the rendition of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, a portion of those costs may be allowable that are incurred by the university medical school and are directly related to the training program for the interns and residents working in the university hospital.

* * *

Sincerely yours,

[signed]

Linda M. Magno
Director, Division of Hospital
Payment Policy

LEGISLATIVE HISTORY OF MEDICARE ACT

— HEARINGS ON H.R. 1

Excerpts of: Medical Care for the Aged: Hearings on H.R. 1 and Other Proposals Before the House Committee on Ways and Means, 89th Cong., 1st Sess. 223, 247 (Feb. 2, 1965)

Mr. ULLMAN. One of the problems, and we came to this when we were analyzing the method of cost indexing of these hospitals, is the fact that most hospitals are charging off a lot of their extras in the ordinary hospital bill. Isn't it true that in every hospital bill there is a great deal of cost involved covering more or less extraneous factors such as training programs for nurses that might be financed some other way?

Have you thought of any alternative?

Dr. CROSBY. On the principles of payment which we advocate the third party bear we recommend that they pay a reasonable amount for education within these hospitals. This is not only education of nurses, but it is education of interns, and residents, and the other paramedical field, technicians of one sort or another, physical therapists and so forth.

H.R. REPORT NO. 213

Excerpt of: Social Security Amendments of 1965, Report on H.R. 6675, 89th Cong., 1st Sess. 32 (March 29, 1965)

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance

the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

SENATE REPORT NO. 404
Excerpt of: Social Security Amendments of 1965, S. Rep. No. 404, 89th Cong., 1st Sess. 36 (June 30, 1965)

Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

EXCERPT OF AMERICAN HOSPITAL ASSOCIATION'S PRINCIPLES OF PAYMENT FOR HOSPITAL CARE

2.302

In determining reimbursable cost, a reasonable amount for medical, nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion in the interest of continuing to upgrade quality of service to the community.

COMMENT . . . Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining reimbursement cost of hospital service until the community is prepared to assume this educational responsibility. Hospitals and third-party purchasers must seek methods for transferring this cost to the whole community through concerted joint effort. It must be borne in mind that nursing education traditionally has been supported by hospital income and by the service rendered by student nurses in hospitals. While financing from other methods must be developed, nothing must be done to discourage the education of increasing numbers of nurses prior to the time that such cost can be transferred to other sources.

EXCERPTS OF REGULATORY HISTORY OF 42 C.F.R. § 413.85

20 C.F.R. § 405.421 (1966)

31 Fed. Reg. 14808, 14814 (Nov. 22, 1966): Department of Health, Education and Welfare, Title 20 - Employees' Benefits, Chapter III — Social Security Administration, Part 405 - Federal Health Insurance of the Aged, Principles for Reimbursable Costs

§ 405.421 Cost of educational activities.

(a) *Principle.* An appropriate part of the net cost of approved educational activities is an allowable cost.

(b) *Definitions*—(1) *Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(2) *Net cost.* The net cost means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations.

(3) *Appropriate part.* Appropriate part means the net cost of the activity apportioned in accordance with the methods set forth in these principles.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the

community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

(d) *"Orientation" and "on-the-job training".* The costs of "orientation" and "on-the-job training" are not within the scope of this principle but are recognized as normal operating costs in accordance with principles relating thereto.

(e) *Approved programs.* In addition to approved medical, osteopathic, and dental internships and residency programs, recognized professional and paramedical educational and training programs now being conducted by provider institutions, and their approving bodies, include the following:

	Program	Approving bodies
(1)	Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology of the American Society of Clinical Pathologists.
(2)	Dietetic internships . . .	The American Dietetic Association.

(3) Hospital administration residencies	Members of the Association of University Programs in Hospital Administration.
(4) Inhalation therapy	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(5) Medical records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(6) Medical technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(7) Nurse anesthetists	The American Association of Nurse Anesthetists.
(8) Professional nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.

(9) Practical nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(10) Occupational therapy	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(11) Pharmacy residencies	American Society of Hospital Pharmacists.
(12) Physical therapy	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(13) X-ray technology	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

(f) *Other educational programs.* There may also be other educational programs not included in the foregoing in which a provider institution is engaged. Appropriate consideration will be given by the intermediary and the Social Security Administration to the costs incurred for those activities that come within the purview of the principle when determining the allowable costs for apportionment under the health insurance program.

PREAMBLE AND REVISIONS TO 42 C.F.R. § 405.421(g)(1), 45 FED. REG. 51783, 51786-87 (AUG. 5, 1980)

Excerpts:

45 Fed. Reg. at 51783 —

SUMMARY: This final rule amends the regulation governing Medicare payments to providers of services for their costs of approved educational activities. Under the current regulation, providers are required to deduct all grants designated for specific education programs from their costs of those programs in calculating their costs that are reimbursed by Medicare. Under the amended regulation, providers will not be required to deduct grants for primary care internship and residency programs. The rule is intended to avoid nullifying the purposes of specific grants for these programs.

* * *

Background

Under Medicare, a provider of services (a hospital, skilled nursing facility or home health agency) is reimbursed on the basis of the costs it incurs in furnishing services to Medicare beneficiaries. Current Medicare regulations specify that, in determining the costs reimbursed under Medicare, the provider may include its net costs of educational activities approved in accordance with the regulations at 42 CFR 405.421. Net cost is currently determined by deducting all grants, tuition, and specific donations from the provider's incurred costs for the educational activity (42 CFR 405.421(b)(2)). However, we have found that these deductions undermine the purpose of grant programs designed to support primary care internship and residency programs. Specifically, the deduction of a grant reduces the provider's costs recognized for Medicare reimbursement, thereby preventing the provider from realizing the full benefit of the grant. We believe this thwarts one of the purposes of title VII of the Public Health Service Act, which is to foster the

development of programs designed to train physicians in primary care specialties. Therefore, we have changed the regulation to specify that deductions will not be made for grants and donations received to support these programs. Instead, if hospital revenues for these programs exceed cost, HCFA will notify grant donors so they may make adjustments if called for.

* * *

42 Fed. Reg. at 51786-51787 —

42 CFR 405.421 is amended by revising paragraph (a), redesignating paragraph (b)(1) as paragraph (b), deleting paragraphs (d)(2) and (b)(3), and adding new paragraphs (g) and (h) to read as follows:

§ 405.421 Cost of educational activities.

* * *

(g) *Calculating net cost.* (1) Except as specified in paragraph (g)(2) of this section, net costs of approved educational activities are determined by deducting from a provider's total costs of these activities, revenues it receives from tuition, and from grants and donations that the donor has designated for the activities. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

PREAMBLE AND REVISIONS TO 42 C.F.R. § 405.421(g), 49 FED. REG. 234, 296 (JAN. 3, 1984)

Excerpt:

Comment—One commenter questioned whether paragraphs (g) and (h) of § 405.421, which deal with the treatment of grants and donations, should be removed as the result of the deletion of § 405.423 (Grants, gifts, and income from endowments) in the interim final rule.

Response—We agree that a revision is necessary. We have therefore revised § 405.421 by revising paragraph (g)(1) and removing paragraphs (g)(2) and (h). This change merely makes the regulations consistent with the change that was made in the interim final.

Grants, gifts and income from endowments—Section 405.423 was eliminated effective for cost reporting periods beginning on or after October 1, 1983. As a result, restricted grants and gifts will no longer be used to offset costs. We received several comments commending us for making this change in policy.

42 C.F.R. § 413.85 (1985)

§ 413.85 Cost of educational activities.

(a) Payment — (1) General rule. Except as provided in paragraph (a)(2) of this section, a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section. The net cost is subject to apportionment based on Medicare utilization as described in § 413.50.

(b) Definition — Approved educational activities. Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) Educational activities. Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the

community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

* * * *

(g) Calculating net cost. Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

PREAMBLE AND REVISIONS TO 42 C.F.R. § 413.85, 54 FED. REG. 40286, 40288, 40301, 40302 (SEPT. 29, 1989)

Excerpts:

54 Fed. Reg. at 40288 —

1. Determining Base-Period per Resident Amounts

   a. Methodology

* * *

In establishing the base-period per resident amount for a specific hospital based on FY 1984 GME costs, it is important that the amount determined be an accurate reflection of legitimate GME costs incurred during the FY 1984 base period. Because the payment methodology required by section 1886(h) of the Act sets future payments using the FY 1984 base-period amounts as the initial starting point, we believe that it is very important that inappropriate costs not be included in the base-period amount. Therefore, we proposed to instruct Medicare contractors to reexamine FY 1984 GME costs and to request appropriate supporting documentation in those cases in which reported costs seem questionable.

54 Fed. Reg. at 40301 —

Comment: One commenter suggested that, during any reaudit activity, hospitals should be able to introduce additional GME costs not previously claimed, as well as misclassified costs, to augment base-period GME costs.

Response: We would seriously question the legitimacy of costs introduced 4 or 5 years after the base-period cost report was prepared by the hospital. However, if it can be demonstrated to the satisfaction of the fiscal intermediary that legitimate GME costs were inadvertently omitted from the base-period cost report, then these costs could be introduced during the reaudit activity. However, these costs would have to

be supported by actual documentation developed during the GME base period that was maintained in a format that can be audited. Costs other than GME costs could not be introduced if the cost report is not otherwise subject to being reopened.

54 Fed. Reg. at 40302 —

Comment: Some commenters expressed concern about treatment of GME costs of a related medical school. One commenter pointed out that, in some complexes, GME activities may take place in space assigned to the medical school, and that it would be unfair to impose a restriction on the location of allowable GME patient care activities in large academic health care centers for reimbursement purposes. Another commenter was concerned that medical schools often are adequately funded by grants from State and local governments, so it seems inappropriate for the medical school under such circumstances to also pass-through such costs to the hospital. In the opinion of the commenter, we should address whether there is a redistribution of GME costs when State appropriations or other funding sources are sufficient to cover the costs of operating the medical school.

Response: We agree that determination of allowable costs of related medical schools can be a complicated matter. We are guided by the general principle that, to be allowable at all, the costs must be related to patient care furnished in the hospital, and, to be allowable as a direct GME cost, the costs must be related to the GME program in the hospital. Certain identifiable activities conducted by the faculty of a related medical school, which are necessary for the clinical training function at the hospital, may represent allowable costs for Medicare program purposes. These activities include supervision of interns and residents in activities for which no Part B charge is made and the conducting of rounds and patient care conferences related to hospital patients. To reiterate, services that are both related to the care and treatment of the hospital's patients and furnished in

support of the training of interns and residents meet the requirements for payment.

These items and services must be necessary and directly related to the provision of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, a portion of those costs that are incurred by the university medical school may be allowable if it can be demonstrated to the satisfaction of the fiscal intermediary that such costs are directly related to the training program of the interns and residents working in the university hospital and are related to the care and treatment of the hospital's patients.

In the past, hospitals have alleged that the related organization principle set forth in § 413.17 requires Medicare to reimburse a hospital for a share of all costs of a medical complex or even of the entire university on the basis that the component entities were indistinguishable from the whole. Our policy concerning related organizations was established to avoid program recognition of costs of a provider for services furnished by a related organization in excess of the costs incurred by the related organization, and to avoid payment of artificially inflated costs that might be generated from less than arm's length bargaining. This policy was not intended to expand the range of items and services for which a provider could claim Medicare reimbursement, or to include items and services not specifically related to patient care.

With respect to the comment that we should address the issue of funding that covers the costs of operating the medical school, our policy prior to October 1, 1983 provided that restricted grants (those grants that were designated by the donor for paying certain specified provider costs) were deducted from the designated costs incurred by the provider. Unrestricted

contributions, however, would not be deducted from such costs. Section 901 of the Omnibus Budget Reconciliation Act of 1980 (Pub. L. 96-499) added section 1134 of the Act. This provision affirmed the Secretary's authority not to offset donor-restricted grants and gifts that the Secretary finds, in the best interests of needed health care, should be encouraged. The policy that restricted grants could be offset against allowable costs incurred by providers was changed effective October 1, 1983 (as provided in the September 1, 1983 final rule (48 FR 39797)). Thereafter, any grant monies received by a provider could not be offset against the reimbursable amounts due the provider under Medicare.

PREAMBLE AND REVISIONS TO 42 C.F.R. § 413.85, 57 FED. REG. 43659 (SEPT. 22, 1992)

* * *

Excerpts:

57 Fed. Reg. at 43660 —

SUMMARY: This proposed rule would set forth in regulations our policy on Medicare payment for the costs of approved nursing and allied health education programs, an action directed by section 6205(b)(2) of the Omnibus Budget Reconciliation Act of 1989. In addition, it would implement the provisions of sections 4004(b)(1) and (2) and 4159(b)(1) and (2) of the Omnibus Budget Reconciliation Act of 1990. In general, except for the changes required by the latter statute, the provisions set forth in this proposed rule restate or clarify our current policies governing these costs, which have been previously set forth in the Provider Reimbursement Manual and other documents but have not been included in the regulations. We also are proposing to amend the list of approved nursing and allied health education programs and to clarify the payment method-

ology for certified registered nurse anesthetist education programs.

I. Background

Medicare has historically paid providers for its share of the costs they incur in connection with approved educational activities. The activities may be broken down into the following three general categories to which different payment policies apply:

- Approved graduate medical education (GME) programs in medicine, osteopathy, dentistry, and podiatry. Current policy on Medicare payment for GME costs is found at 42 CFR 413.86, which was added by a final rule published in the Federal Register on September 29, 1989 (54 FR 40286). In general, for each hospital cost reporting period beginning on or after July 1, 1985, GME costs are paid on the basis of a hospital-specific per resident amount multiplied by the hospital's weighted number of full-time equivalent (FTE) residents for that cost reporting period.
- Approved nursing and allied health (paramedical) education programs operated by the provider. The costs of these programs are excluded from the definition of inpatient operating costs and are not included in the calculation of payment rates under the prospective payment system or in the calculation of the target amount subject to the rate of increase ceiling for hospitals and hospital units excluded from the prospective payment system. These costs are separately identified and "passed through" (that is, paid on a reasonable cost basis).
- Other educational programs and activities.

All other costs that can be categorized as educational programs and activities are considered to be part of normal operating costs and have been covered by the per case payments made under the inpatient hospital prospective payment system for hospitals subject to that system or on the basis of reasonable

cost subject to the rate-of-increase limits for hospitals and hospital units excluded from that system.

This proposed rule discusses the history of Medicare and the costs associated with approved nursing and allied health education programs and sets forth our proposed policy on payment for these costs.

A. The Social Security Amendments of 1965 (Pub. L. 89-97)

The subject of Medicare payment for a provider's costs of educational activities arose during the committee hearings prior to the establishment of the Medicare program with the enactment of Public Law 89-97. In January and February 1965, a representative from the American Hospital Association (AHA) testified before the House Committee on Ways and Means. The representative testified that the AHA advocated that third parties pay a reasonable amount for education within the hospitals, not only for nurses but also for interns, residents, technicians, and the other allied health fields (H.R. Rep. No. 213, 89th Cong., 1st Sess. 33 (1965)). At the same hearing, the Commissioner of the Social Security Administration testified that, on the matter of educational costs, the principles of the AHA would be followed.

Thus, in complying with the reports of the committee, the drafters of the regulations implementing title XVIII of the Act were guided by the "Principles of Payment for Hospital Care" first published by the AHA in 1953, with slight modification in 1961 and 1963. The AHA's Reimbursement Principle No. 2.302 stated that, "In determining reimbursable cost, a reasonable amount for medical, nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion in the interest of continuing to upgrade quality of service to the community." The publication went on to comment that —

> Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining reimbursable cost of hospital service until the community is prepared to assume this educational responsibility. Hospitals and third-party purchasers must seek methods for transferring this cost to the whole community through concerted joint effort. It must be borne in mind that nursing education traditionally has been supported by hospital income and by the service rendered by student nurses in hospitals. While financing from other methods must be developed, nothing must be done to discourage the education of increasing numbers of nurses prior to the time that such cost can be transferred to other sources.

57 Fed. Reg. at 43661 —

Title XVIII of the Act created a 16-member body to provide advice in the formulation of Medicare regulations. This group, the Health Insurance Benefits Advisory Council, met in December 1965 and included the costs of educational activities in its discussion of Medicare reimbursable costs. The minutes of this meeting show that the Council considered the following principle: "A part of the net cost of educational activities shall be included as an element of reimbursable cost." The Council accepted the principle, subject to the inclusion of the word "approved" before the words "educational activities." It asked the staff to study further the problem of differentiating between

teaching related to patient care and teaching unrelated to patient care. In January 1966, when the Council met again, comment was made that the resolutions comprise only a basic statement of policy and that the Administration would have to refine the policies to adapt them to various situations, formulate and publish regulations, and establish guidelines and procedures, both to implement the policy recommended by the Council and to prevent abuses. This position was consistent with the definition of "reasonable cost" in the original section 1861(v)(1)(A) of the Act, which authorizes the Secretary to define "reasonable costs" in various circumstances by issuing implementing regulations. The Council confirmed by formal voting procedures that "the net cost of approved educational activities should be included as an element of reimbursable cost."

There was no statutory requirement in Public Law 89-97 nor in any subsequent amendment to title XVIII of the Act specifying the types of nursing and allied health education programs for which Medicare should pay its share of the costs. However, both the House and Senate Committee reports accompanying Public Law 89-97 indicate that Congress favored including a part of educational expenses as allowable costs:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

(S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965)).

(In this document, we have substituted the term "allied health" for "paramedical," since Medicare currently allows the costs of approved training programs for medical records librarians, medical technologists, and other disciplines for which the term "allied health" is more appropriate, and this is the term most commonly used to refer to this category of health care professions.)

B. Net Cost of Approved Educational Activities

The regulation that evolved from this legislation, 20 CFR 405.421 (redesignated as 42 CFR 405.421 on September 30, 1977 and as 42 CFR 413.85 on September 30, 1986), was first published in the Federal Register on November 22, 1966 (31 FR 14814). In the original regulation (20 CFR 405.421(b)(2)), net cost was defined as "the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations." The regulations also defined approved educational activities as "formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution." (20 CFR 405.421(b)(1).)

The types of costs that were allowable as costs of approved educational activities early in the Medicare program were set forth in both the applicable regulation and in Chapter 4 of the Provider Reimbursement Manual (HCFA-Pub. 15-1). The original regulation specifically excluded "orientation" and "on-the-job training" from the definition of approved educational activities (20 CFR 405.421(d)). Further, as early as 1971, Chapter 4 of the Provider Reimbursement Manual stated that "any costs of usual patient care" are also excluded from that definition (§ 404.2). The Provider Reimbursement Manual specified that the costs of usual patient care were allowable, but only as normal

operating costs and not as educational costs. On the other hand, during this time, the Provider Reimbursement Manual did include within the scope of allowable educational activities, under certain conditions, such other educational expenses as costs associated with refresher and postgraduate programs, part-time education for bona fide employees of the provider, travel expenses for educational workshops, and training in the use of medical appliances for patients or their care-givers.

Both the regulation and the Provider Reimbursement Manual repeated the congressional committee report language from 1965 that Medicare would share in the costs of educational activities until communities bore them in some other way. Neither of these sources, however, included any criteria to use in determining whether responsibility for a program had been assumed by a community. Nonetheless, it was clearly stated in both the regulation and the Provider Reimbursement Manual that it was not intended that Medicare should pay for increased costs resulting from a redistribution of costs from educational institutions to providers (20 CFR 405.421(c) and § 404.2 of the Provider Reimbursement Manual).

* * *

57 Fed. Reg at 43662 —

H. The January 1983 Provider Reimbursement Manual Revision

* * *

Section 404.2 of the Provider Reimbursement Manual, as revised in January 1983, specified that provider costs incurred for clinical training associated with an approved program operated by an entity other than a provider could be allowable. Further, it specified that costs incurred by a provider that were associated with the classroom portion of the program could be allowable if the following three criteria were met:

- The provider's support does not constitute a redistribution of nonprovider costs to the provider. The support must be in addition to the costs already being incurred by the nonprovider-operated program. If the nonprovider entity reduced its costs due to receiving provider support, this reduction constitutes a redistribution of costs from an educational institution to a patient care institution and is a nonallowable provider cost.
- The provider receives a benefit for the support it furnishes.

57 Fed. Reg. at 43663 —

- The cost of the provider's support is less than the cost the provider would incur were it to operate the program.

These criteria adopted in January 1983 addressed the allowability of costs incurred by a provider in support of a nonprovider-operated educational program. Since the revision to Chapter 4 of the Provider Reimbursement Manual predated the Medicare prospective payment system for inpatient hospital services, it did not address the issue of whether such costs were to be considered part of normal operating costs or treated as a "pass-through cost."

* * *

57 Fed. Reg at 43665 —

II. Proposed Revisions

* * *

57 Fed. Reg. at 43668 —

D. Definition of Net Costs

We are proposing to revise the current definition of net costs. The definition currently states "net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition."

When the regulations were revised, it was assumed that the tuition paid by students enrolled in approved educational programs was intended to cover all facilities and services for which a provider would incur costs. It was not our intention to imply that costs for which a provider charges a separate fee, in addition to tuition, were not to be considered as part of the cost of the approved educational activity. Two examples of such costs are the purchase of textbooks for resale to students and the provision of housing or room and board in exchange for an additional fee. We are proposing to clarify in the regulations that the term "tuition" was intended to include these additional charges and fees.

We also are clarifying the definition of net costs in the proposed regulations to indicate that "total costs" was intended to include only direct and indirect costs incurred by a provider that are directly attributable to the operation of an approved educational activity. Such costs do not include usual patient care costs that would be incurred in the absence of the educational activity, such as the salary costs for nursing supervisors who oversee the floor nurses and student nurses. Moreover, we believe that such costs do not include costs incurred by a related organization. The current regulation concerning related organizations at § 413.17 was established to avoid program recognition of artificially inflated costs that might be generated from less than arm's length bargaining. This policy was not intended to expand the range of items and services for which a provider could claim payment. With respect to educational costs (with the limited exception for certain graduate medical education costs incurred by a related medical school as provided in Intermediary Letter 78-7), our policy has been that the provider, rather than the related organization, must directly incur the costs on its books and records before the costs will be recognized for Medicare payment purposes. Otherwise, the principle that Medicare payment for medical education costs should not result

in a redistribution of costs from the educational institution to the provider would be violated.

* * *

In the final rule of January 3, 1984 (49 FR 234), the definition of net costs in paragraph (g) of § 405.421 (now § 413.85(g)) was revised by eliminating grants and donations from revenues that were to be offset against the cost of approved educational activities. This revision was made in response to a public comment to ensure that the policy on net cost of educational activity would be consistent with the policy that deals with the treatment of grants, gifts, and income from endowments under reasonable cost payment under § 413.5(c)(3). However, we are reconsidering our position on this issue. As a result, we are requesting public comment on whether the net costs of approved educational activities should be defined as the costs determined by deducting the revenues that a provider receives from tuition, student fees, and the allocable amounts from any donations, grants, and non-Medicare public funding from the provider's total allowable costs that are directly related to approved educational activities.

* * *

57 Fed. Reg. at 43671 —

We are proposing to amend 42 C.F.R. part 413, subpart F as set forth below:

* * *

2. Section 413.85 is revised as follows:

§ 413.85 Cost of approved educational activities.

(a) *General payment rule*. Except as provided in paragraph (b) of this section, payment for a provider's net cost of approved educational programs is determined on a reasonable cost basis.

(b) *Payment on other than a reasonable cost basis*. (1) *Graduate medical education programs*. For cost reporting periods beginning on or after July 1, 1985, payment to hospitals and

hospital-based providers for approved residency programs in medicine, osteopathy, dentistry, and podiatry is determined as provided in § 413.86.

* * *

57 Fed. Reg. at 43672 —

(c) *Definitions*. (1) *Net costs*. Net costs of approved educational activities means the costs determined by deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable costs that are directly related to approved educational activities. For this purpose, a provider's total allowable costs include costs incurred by the provider for trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24. Except as provided in paragraph (f) of this section, total allowable educational costs do not include usual patient care costs, costs incurred by a related organization, or costs that constitute a redistribution of costs from an educational institution to a provider. Net cost is subject to apportionment for Medicare utilization as described in § 413.50.

(2) *Redistribution of costs*. Redistribution of costs is defined as an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider and were considered costs of an educational institution. For example, costs for a school of nursing or allied health education that were incurred by an educational institution rather than the provider in its prospective payment or rate-of-increase limit base year cost report are not allowable costs in subsequent fiscal years.

* * *

PROVIDER REIMBURSEMENT MANUAL, PART 1, § 404.2

Costs of Approved Nursing and Paramedical Education Programs

The responsibility for operating and supporting approved educational programs which are necessary to meet the community's needs for nursing and paramedical personnel should be borne by the community. Where the community has not yet recognized and accepted this responsibility, the Medicare program does participate appropriately in the support of such approved programs as are operated by providers in conjunction with their patient care activities. However, it is not intended that Medicare should be responsible for expenditures by a provider in subsidizing such programs that are operated by other organizations where the provider receives no, or disproportionately little, benefit for the amount it expends.

Accordingly, a provider's reasonable costs associated with approved nursing and paramedical education programs are allowable as follows:

A. Provider-Operated Programs. — Costs incurred in these programs including costs of classroom training and costs of clinical training are allowable.

B. Non-provider-Operated Programs Supported by Providers. — The manner in which provider support whether in cash or in kind is furnished may vary depending on the circumstances. The classroom portion of these programs is often, but not always, conducted in a non-provider setting. The clinical training portion generally is conducted in a provider or other health care setting. Costs incurred for the clinical training at the provider are allowable. Costs incurred which are related to the classroom portion are allowable if the following three criteria are met.

1. The provider's support does not constitute a redistribution of non-provider costs to the provider.

   The support must be in addition to the costs already being incurred by the non-provider operated program. If the non-provider reduces its costs due to receiving provider support, such reduction constitutes a redistribution of cost from an education institution to a patient care institution and as such is not an allowable provider cost. Reg. 405.421(c).

2. The provider is receiving a benefit for the support it furnishes.

3. The provider's support is less than the cost the provider would be expected to incur with a program of its own.

Examples of Provider Support. —

1. A provider begins support of a new, or an expansion of an existing, non-provider program for the purpose of assuring an adequate supply of trained staff not otherwise available in the area. Criterion No. 1 is met because the support is for costs not previously borne by the non-provider. Criterion No. 2 is met because the provider is receiving a benefit, i.e., assurance of availability of trained staff, for the support it furnishes. For criterion No. 2 to continue to be met, the provider must be able to document on an ongoing basis that it continues to receive a supply of trained staff. Criterion No. 3 will be met if the provider can document that it will incur less cost under this arrangement than it would incur with a program of [its] own.

2. A provider agrees to support a non-provider program already supported by other providers in order to assure itself an adequate supply of trained staff not otherwise available in the area. There is no increase in the total amount of support being made by all of the participating providers except for increases reasonably related to inflation. Criterion No. 1 is met because the provider is not bearing costs previously borne by the non-

provider but rather costs that were borne by the other providers. Criterion No. 2 is met so long as the provider can document that it continues to receive the benefit of a supply of trained staff for the support it furnishes. Criterion No. 3 will be met if the provider can document that it will incur less cost under this arrangement [than] it would incur with a program of its own.

C. Clinical Training Conducted in a Provider Setting Where Classroom Training Costs Are Not Allowable. — Costs of clinical training are allowable provided the training is conducted in conjunction with an approved program and relates to the care of provider patients.

No. 93-120

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

THOMAS JEFFERSON UNIVERSITY
d/b/a Thomas Jefferson University Hospital,
Petitioner,

v.

DONNA E. SHALALA, SECRETARY
Department of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

Under applicable Medicare regulations, hospitals that furnish services to Medicare beneficiaries are entitled to be reimbursed for the "reasonable cost," including direct and indirect costs, of certain education programs for health professional trainees, including residents. The programs for the training of residents are referred to as graduate medical education or GME programs. The Secretary denied the Hospital reimbursement for the actual reasonable costs of operating its GME programs using a novel interpretation of regulations in force for over 20 years. The question presented for review is:

Whether the Secretary's denial of Petitioner's claim for the reasonable costs of its GME programs on the ground that the claim constituted an impermissible redistribution, and on the ground that the community had undertaken to support those programs, is arbitrary, capricious, an abuse of discretion and not in accordance with law.

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No. 93-120

IN THE

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ON WRIT OF CERTIORARI TO THE
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BRIEF FOR THE PETITIONER

OPINIONS BELOW

The United States Court of Appeals for the Third Circuit issued a judgment, but no opinion. The judgment (Pet. App. 1a-2a) is not reported. The opinion of the United States District Court for the Eastern District of Pennsylvania (Pet. App. 3a-25a) is not reported.

There are two administrative decisions concerning this case. The Provider Reimbursement Review Board ("PRRB") is the administrative tribunal with jurisdiction to hear and review Medicare reimbursement disputes. Its decision in this matter, PRRB Dec. No. 90-D5 (Pet. App. 38a-60a), is reported in [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,276 (Nov. 17, 1989). The Administrator of the Health Care Financ-

ing Administration ("HCFA") is the agent of the Secretary of the Department of Health and Human Services (the "Secretary") with authority to review PRRB administrative determinations. Decisions of the Administrator constitute final agency action. The Administrator's decision (Pet. App. 28a-37a) is reported in [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,353 (Jan. 18, 1990).

JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit was entered on April 21, 1993. Pet. App. 2a. The petition for a writ of certiorari was filed on July 20, 1993, and was granted on January 10, 1994. This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory provision, 42 U.S.C. § 1395x(v)(1)(A), is reprinted at Pet. App. 61a-62a. The relevant regulatory provision, 42 C.F.R. § 413.85, is reprinted at J.A. 40-41.

STATEMENT OF THE CASE

Thomas Jefferson University Hospital (the "Hospital") is a 700-bed teaching hospital (Pet. App. 8a),[1] and a participating provider in the Medicare program. Pet. App. 5a. The Hospital is owned and operated by Thomas Jefferson University ("University"), a private, not-for-profit educational institution which also owns and operates the Jefferson Medical College (the "Medical School") and other entities. Pet. App. 8a. Thomas Jefferson University was founded in 1824. *Id.* The Hospital was opened in 1877, and has been in continuous operation since

[1] Items from the record in this case are cited to the Appendix to the Petition for a Writ of Certiorari ("Pet. App. __"), the Joint Appendix ("J.A. __"), or the Administrative Record, which was filed in the district court below ("A.R. __").

then. *Id.* The Hospital is an approved Medicare provider (Pet. App. 5a), and has participated in the program since its inception in 1966. Pet. App. 8a. This case involves a dispute over the proper amount of Medicare reimbursement due the Hospital for its fiscal year ended June 30, 1985.

A. The Medicare Program

Title XVIII of the Social Security Act established the federally-funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. § 1395 *et seq.* Under the hospital insurance provisions of the Medicare Act, payments are not made to individual beneficiaries; instead, the Medicare program reimburses participating hospitals ("providers") for the costs of treating eligible beneficiaries.

Determination of the amount of Medicare reimbursement to which a provider is entitled is a multi-step process. A provider first files a cost report with its "fiscal intermediary" (typically an insurance company which, pursuant to contract with the Secretary, provides payment to providers). This cost report is the basis for the calculation of the provider's Medicare reimbursement. 42 C.F.R. §§ 413.20(b), 413.24(f). Upon receipt of a provider's cost report, the fiscal intermediary analyzes the reported data, undertakes any necessary audits, and informs the provider, through a written Notice of Program Reimbursement, of the amount of Medicare reimbursement to which the provider is entitled. 42 C.F.R. § 405.1803. If the provider is not satisfied with this determination, and the total amount in controversy is at least $10,000, the provider may request a hearing before the PRRB. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835. The PRRB serves as a tribunal within the Department charged with exclusive jurisdiction over Medicare cost reimbursement claims. The members of the PRRB are required by statute to be knowledgeable in the field of Medicare cost reimbursement and at least one of them must be a certified public accountant. 42 U.S.C. § 1395oo(h).

For fiscal years beginning on or after October 1, 1983, providers are reimbursed for the costs associated with the provision of inpatient hospital services to Medicare beneficiaries pursuant to a prospective payment system. 42 U.S.C. § 1395ww(d). However, certain categories of costs incurred by providers, including medical education costs, are exempt from prospective payment. 42 U.S.C. § 1395ww(a)(4). For the cost year at issue, a provider's approved medical education costs were reimbursed on a retrospective, reasonable cost basis. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.85.[2]

Reasonable costs are to be determined in accordance with methods adopted by the Secretary. Congress specifically directed, however, that such methods must not result in other purchasers of a hospital's services bearing any of the costs of treating Medicare patients, nor in Medicare bearing any of the costs of treating non-Medicare patients. 42 U.S.C. § 1395x(v)(1)(A). This prohibition against cross subsidization has always been a feature of the Medicare program, and is the standard by which the Secretary's determinations with regard to reimbursable costs must be judged. *See Loyola University of Chicago v. Bowen*, 905 F.2d 1061, 1073 (7th Cir. 1990); *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1212 (6th Cir. 1989).

The Medicare statute defines "reasonable costs" broadly:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . .

[2] From the inception of the Medicare program in 1966 through fiscal years beginning before July 1, 1985, graduate medical education costs were reimbursed on a retrospective, reasonable cost basis. Congress changed the method of reimbursing GME costs, effective for fiscal years starting after June 30, 1985, to one which is based on a provider's average cost per GME resident in a past year. 42 U.S.C. § 1395ww(h).

42 U.S.C. § 1395x(v)(1)(A). The Secretary's regulations define reasonable costs as the "direct and indirect costs of providers of services" and include "all necessary and proper costs incurred in furnishing the services." 42 C.F.R. § 413.9(a), (b)(1). The term "necessary and proper costs" is similarly defined broadly to mean "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." 42 C.F.R. § 413.9(b)(2).

B. Medicare Reimbursement Of Graduate Medical Education Costs

Reasonable costs include a provider's costs associated with approved GME activities. The regulations at 42 C.F.R. § 413.85 are the governing regulations for the reimbursement of costs associated with educational activities.[3] Section 413.85(a) provides that "a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section." Section 413.85(b) defines approved educational activities as "formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution," and requires that such programs be licensed or receive approval from a recognized national professional organization. 42 C.F.R. § 413.85(b). Subsection (c), which was relied on below to support the Secretary's refusal to reimburse Petitioner for its full graduate medical education costs, provides:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the [Medicare] program will participate appro-

[3] The relevant paragraphs of 42 C.F.R. § 413.85 are set forth in full at J.A. 40-41.

> priately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

42 C.F.R. § 413.85(c). Finally, as relevant here, subsection (g) defines the reasonable costs of operating GME programs as:

> Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 413.24.

42 C.F.R. § 413.85(g).

Medicare regulations allow a hospital to claim the costs incurred by a medical school in connection with the operation of the hospital's GME programs, when the hospital and the medical school are related by common ownership or control.

> [C]osts applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

42 C.F.R. § 413.17(a) (Pet. App. 63a).

The Secretary herself has interpreted this regulation as permitting a provider to claim patient care costs incurred by a

related medical school. For example, in guidelines issued to private entities who administer the Medicare program (intermediaries), the Secretary identified certain costs incurred by related medical schools which could be included in a provider's GME costs, including costs of teaching faculty salaries, a medical library, physician office space and clerical support. *See* Intermediary Letter 78-7 ("IL 78-7") (Pet. App. 64a-65a). These costs normally would be incurred directly by a hospital that operated GME programs independently of a related medical school. *Id.*

There is no dispute that Congress recognized the value of GME programs in enhancing the quality of patient care in health care institutions. Until the community at large undertakes the responsibility to pay the costs associated with GME programs, Congress directed that "part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by [Medicare]." S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1977 (J.A. 32). *See also* H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965) (J.A. 31-32). The Secretary's regulation now found at 42 C.F.R. § 413.85 is "widely accepted" as reflecting this express Congressional intent that the Medicare program share in the cost of GME programs. Pet. App. 14a-15a. The regulation also reflects Congress' understanding that GME programs contribute to the quality of patient care for Medicare and non-Medicare patients.

The relevant statutory provisions and regulations at issue here have been part of the Medicare Act and regulatory scheme since the program's inception.[4] Despite this fact, the Secretary

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[4] The regulation which is now designated 42 C.F.R. § 413.85 was first published in the Federal Register on November 22, 1966, 31 Fed. Reg. 14808, 14814 (J.A. 34). Originally, the regulation was designated 20 C.F.R. § 405.421. It was redesignated 42 C.F.R. § 405.421 on September 30, 1977

did not begin to treat claims for reimbursement of related-party medical school costs as raising any issues regarding "redistribution" until the mid-1980s. Moreover, although section 413.85(c) has always been a part of the Medicare regulatory scheme, the Secretary concedes that no criteria have ever existed for determining when community support exists. J.A. 51. The Secretary never formally defined "redistribution" until she issued her proposed modifications to section 413.85(c) in September 1992. J.A. 55.

In the absence of any formal definition, the only meaning to be ascribed to the "community support" and "redistribution" concepts comes from the relevant legislative history, the Secretary's own previous interpretations and practices, and the plain meaning of the regulation, read in context with the entire statutory and regulatory scheme. These sources demonstrate that the interpretation of the regulation adopted by the Secretary here is not supported by the legislative history, and is directly contrary to the Secretary's own previous interpretations of the regulation. Moreover, the Secretary's current interpretation is contrary to the plain meaning of the regulation.

C. The Hospital's 1985 Claim For GME Costs

The Hospital is the approved operator of GME programs in various specialties and subspecialties. Pet. App. 39a. In 1985, the Hospital's GME programs involved 320 full-time equivalent residents. *Id.* There is no dispute that the Hospital's GME programs contribute to the quality of patient care in the Hospital. Pet. App. 17a. Although the Hospital has participated

(42 Fed. Reg. 52886), and as 42 C.F.R. § 413.85 on September 30, 1986 (51 Fed. Reg. 34790). On September 29, 1989, the Secretary promulgated a new regulation, 42 C.F.R. § 413.86, to implement a new payment methodology for the clinical education of interns and residents. *See* 54 Fed. Reg. 40286 (Sept. 29, 1989) (J.A. 42). On September 22, 1992, the Secretary proposed certain modifications to 42 C.F.R. § 413.85. *See* 57 Fed. Reg. 43659-73 (Sept. 22, 1992) (J.A. 45). The Preamble to that proposed regulation contains a discussion of the history of the GME regulation. J.A. 47-51.

in the Medicare program since 1966, it did not begin claiming related-party GME costs (that is, costs incurred by the Medical School) until 1974. Pet. App. 8a. When it initially claimed GME costs in 1974, those costs were paid by the program. *See* Pet. App. 32a. The Secretary did not assert in 1974, or thereafter, that the Hospital's failure to claim GME costs from 1966-73 was "presumptive" evidence that the community had been supporting the Hospital's GME programs. *Id.*; Pet. App. 58a. Nor did the Secretary refuse the Hospital's claim on the ground that it constituted a "redistribution."

Although the Hospital and the Medical School are separate administrative units, they are unincorporated divisions of a single entity, the University. A.R. 132. As such, they are "related parties" under applicable Medicare regulations. 42 C.F.R. § 413.17(a). The University produces an audited financial statement which combines the operations of each of its administrative units (Hospital, Medical School, College of Allied Health Sciences, and College of Graduate Studies). A.R. 131. The Hospital and the Medical School have separate budgets, and the University's policy is that those budgets be balanced. A.R. 132. In 1985, however, the Medical School operated at a deficit. *Id.*

The University is a private institution. It receives limited state support in the form of appropriations from the Commonwealth of Pennsylvania and the State of Delaware. Pet. App. 60a. Both of these appropriations, however, are specifically limited to use for undergraduate medical education. *Id.* Thus, the University receives no public funding whatsoever for its graduate medical education programs.[5] The other Medical

[5] Even though state appropriations have increased each year, the *percentage* of the Medical School's costs which is funded by state appropriations has been steadily decreasing. In 1972-73, the appropriation from Pennsylvania made up 35 percent of the medical school's operating costs. Pet. App. 60a. Between 1973 and 1984 state appropriations increased 24 percent, but in 1984, the state appropriation constituted just 16 percent of the Medical

School sources of funding include undergraduate tuition (which increased 360 percent between 1973 and 1983) (A.R. 142), funds the Hospital transfers to the Medical School for services rendered to the hospital, gifts and grants, and practice plan revenues (physician charges to patients). A.R. 819.

The Hospital's 320 full-time-equivalent residents provide services to Hospital patients under the supervision of Medical School faculty. GME training activities traditionally occur in hospitals because such activities involve little academic or classroom activity, but rather consist almost entirely of learning through the provision of care to patients, much of which can occur only in a hospital. A.R. 133-34. To operate a GME program, a hospital must either hire faculty and support staff itself or arrange for them to be provided by a medical school. Here, the Hospital relies on the related Medical School to provide the services needed to operate the Hospital's GME programs. Thus, although the Hospital is the licensed operator of the University-approved GME programs, for internal administrative purposes, the Medical School has been delegated the responsibility for administering them. *Id.* The Medical School selects and evaluates the residents; its faculty and their clerical support staff are responsible for assigning, training and supervising the residents; and Medical School facilities are used for carrying out the administrative aspects of these responsibilities. *Id.* The Hospital does not duplicate these activities and their related costs, but instead uses the Medical School's resources as its own. A.R. 135.

Medical School faculty who are full-time are paid by the University for their teaching, administrative and research duties.

School's operating costs of $27,202,000. *Id.*; A.R. 142. During the same period, the Medical School's operating costs increased by 164 percent. A.R. 928.

[6] In 1984, the Hospital claimed and the intermediary allowed additional categories of costs related to its GME programs. *See* Pet. App. 35a n.10.

Historically, the compensation of most full-time faculty is charged to Medical School accounts. A.R. 136. Compensation for some faculty, however, such as those involved in the administration of hospital-based departments (*e.g.*, radiology, pathology), is charged directly to Hospital accounts. A.R. 136. No faculty physicians are compensated by the University for their direct patient care services to individuals. A.R. 183. Faculty physicians bill and are compensated separately for their patient care services through the full-time faculty practice plans. A.R. 183.

For a number of years, the Hospital has reimbursed the Medical School for GME teaching efforts in two ways. First, it has paid directly the salaries of some hospital-based faculty. Second, it has transferred additional money to the Medical School for a portion of faculty salaries attributable to GME teaching efforts, specifically the supervision of residents and interns. Pet. App. 9a. Payments related to faculty teaching efforts were charged to a Hospital account called "professional salaries." *Id.* The amount of the transfer by the Hospital to the Medical School above the direct salaries paid by the Hospital was determined by analyzing "Personal Activity Reports" completed by physicians every six months. *Id.* On these forms, faculty members were asked to account for their time in categories such as research, instruction, sponsored programs, administration and hospital activity. A.R. 139. Based on these reports, the Hospital reimbursed the Medical School for a portion of faculty salaries related to GME activities. Pet. App. 9a.

Prior to 1985, the amount of the claims for related-party costs associated with the GME programs had always been

When the inconsistency in its treatment of the Hospital's claim for additional GME costs between 1984 and 1985 was pointed out, the intermediary conveniently characterized its action in 1984 as a "mistake." *Id.*

[7] Based on the 1985 cost study, the Hospital claimed $6,614,724 in GME costs. Pet. App. 10a. The amount of costs allowed, including amounts

allowed by the intermediary. Pet. App. 40a.[6] Although the system for determining the extent of costs attributable to GME teaching efforts originally was designed to be as accurate as possible, beginning in 1984 and continuing in its 1985 cost year, the Hospital undertook to refine its cost-finding techniques to ensure that all of the costs properly attributable to the operation of GME programs were identified and claimed for reimbursement. Pet. App. 9a. Thus, in 1985, the Hospital engaged a national accounting firm to conduct a cost study to identify all costs related to its ongoing GME programs. *Id.*

The 1985 cost study identified an additional $1,979,091 in Medical School costs attributable to the Hospital's GME programs beyond the costs which had been allowed.[7] If these costs are fully allowed, as Petitioner asserts they should be, the cost to the Medicare program will be approximately $600,000.[8] The portion of the Medical School's total costs for which Medicare reimbursement is sought is quite small. In fiscal year 1985, the Medical School's total costs were nearly $30,000,000. A.R. 819. Moreover, the cost study proves that the costs for which reimbursement is sought were actually incurred in support of the Hospital's GME programs. Pet. App. 57a. Thus, the Secretary's attempt below to raise the specter of wholesale cost shifting from medical schools to hospitals (*see* Pet. App. 34a-35a) is not supported by the record in this case.

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allowed pursuant to a settlement agreement between the Secretary and the Hospital at the district court (*see* J.A. 2), was $4,635,633. Thus, the remaining amount in dispute is $1,979,091.

[8] The Medicare program shares in a provider's allowable costs to the extent Medicare beneficiaries use the provider. *See* 42 C.F.R. § 413.50. In the cost year at issue, approximately 35 percent of the Hospital's allowable costs were paid by Medicare, based on Medicare patients' usage of the Hospital. A.R. 133.

The Hospital's 1985 request for GME program reimbursement was denied by the fiscal intermediary, which claimed that the costs were an impermissible "redistribution." Pet. App. 10a. The Hospital appealed the intermediary's decision to the PRRB. Pet. App. 11a. The PRRB reversed the intermediary's decision and allowed reimbursement of the full costs documented in the cost study. Pet. App. 38a-60a. The PRRB agreed with the Hospital that the cost study complied with the full costing requirements of 42 C.F.R. §§ 413.24 and 413.85(g) by identifying the total allowable costs incurred by the Medical School in support of the Hospital's GME activities, including direct and indirect costs. Accordingly, the PRRB found that the intermediary's disallowances were improper and that the Hospital should be permitted to claim the full amount of GME costs documented by the cost study. Pet. App. 56a.

The PRRB specifically rejected the intermediary's argument that the cost study resulted in a "redistribution" of costs from the Medical School to the Hospital.

> [H]istorically, the Provider has always utilized the services of faculty members of its related Medical School for the supervision and education of the residents in its GME programs. Throughout its participation in the Medicare program, the provider has claimed the costs identified with these educational activities, and there is no evidence that the Intermediary ever disallowed the amounts claimed. . . . In 1985, the Provider performed an in-depth study of its GME programs in order to identify all costs related to its ongoing educational activities. The fact that the Provider did not fully identify all of the costs associated with its GME programs in prior years does not prohibit the correction of this error in the cost reporting period in contention.

Pet. App. 58a-59a.

Upon review, the Secretary, acting through her agent, the Administrator of HCFA, reversed the PRRB. Pet. App. 28a-37a. The Administrator reasoned that since these costs had not been claimed by the Hospital in earlier cost years, they presumptively constituted a "redistribution" of costs previously borne by the "community" (the Medical School) to the Hospital. Pet. App. 35a.[9] In effect, the Secretary has created an irrebuttable presumption that costs of a related-party medical school not previously claimed by a hospital were borne by the community and any later claim for those costs is an impermissible redistribution.

Here, the sources of funding which the Secretary believed constituted "community support" for the Hospital's GME programs included the tuition charged to undergraduate medical students, hospital fees (*i.e.*, charges to sick patients), grants, bequests, and state-funded support for undergraduate medical

[9] The Administrator also concluded that some of the incremental costs claimed by the Provider would not have been allowable even if redistribution were not an issue because they were beyond the scope of costs allowable pursuant to IL 78-7. Pet. App. 37a. The Secretary also raised this issue in the litigation regarding Ohio State University's similar claim for reimbursement. *See Ohio State University v. Sullivan*, 777 F. Supp. 582, 588-89 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir. 1993). The Secretary has abandoned that claim here. According to the Secretary's statement of the question presented to this Court, the issue is: "Whether the Secretary reasonably determined that 42 C.F.R. 413.85(c) bars a hospital providing Medicare services from obtaining reimbursement of *otherwise reimbursable* GME program costs that previously were absorbed by its affiliated medical school." *See* Brief for the Respondent on Petition for Writ of Certiorari, *Thomas Jefferson University v. Shalala*, No. 93-120, at (I) (emphasis added). In other words, if the community support and redistribution principles of section 413.85(c) do not bar the Hospital's claim, the Secretary concedes that they are "otherwise reimbursable." *See also* Secretary's Petition for Writ of Certiorari, *Shalala v. Ohio State University*, No. 93-696, at 6 n.5 (dated November 1993) ("The court also rejected the Administrator's determination that the indirect GME-related costs were not allowable costs under the Medicare Act. . . . That ruling is not at issue here.").

education programs from Pennsylvania and Delaware. Pet. App. 32a. Petitioner asserts that as a matter of fact and a matter of law, none of these sources can appropriately be considered "community support" for GME. Moreover, the Secretary determined that the Hospital's claim constituted a "redistribution" by focusing on only the last clause of the last sentence of the relevant regulation. Her inappropriate fixation on the term "costs" in that sentence led her to ignore totally the part of the sentence which comes before, and which provides that the Medicare program will share in the GME costs of *activities* customarily and traditionally carried on by providers.

The Hospital timely appealed the Secretary's determination to the United States District Court for the Eastern District of Pennsylvania. There, on cross motions for summary judgment, the court determined that the Secretary's interpretation of the community support and redistribution principles of section 413.85(c) were reasonable and entitled to deference. Pet. App. 23a-24a. The Hospital timely appealed the district court's decision to the Third Circuit, which, on April 21, 1993, entered a judgment, with no opinion, affirming the district court. Pet. App. 1a-2a.

SUMMARY OF ARGUMENT

At issue in this case is whether the Hospital is entitled to reimbursement from the Medicare program for certain graduate medical education costs which are related to patient care and incurred by a related medical school. The Medicare statute directs that providers of Medicare services are to be reimbursed for all costs found to be "reasonable" and "necessary" in the delivery of needed health services to Medicare beneficiaries. 42 U.S.C. § 1395x(v)(1)(A). The Secretary does not dispute that the costs at issue here were reasonable and necessary in the delivery of needed health services to Medicare beneficiaries. On the contrary, the Secretary concedes in this Court that, but

for her application of section 413.85(c) to this claim, the costs at issue are reimbursable. *See* n.9, *supra*.

Section 413.85(c) provides:

> Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the [Medicare] program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

42 C.F.R. § 413.85(c).

The Secretary reached her conclusion that the Hospital was "redistributing" costs from an educational unit to a patient care unit in violation of the regulation, by focusing narrowly on whether the Medical School or the Hospital had historically borne the *costs* of GME programs. The Secretary's reading of the regulation focuses exclusively on the last clause of the last sentence of the section, ignoring the regulation's statement of intent to share in the costs of GME *activities* of the type traditionally carried on by providers. Petitioner asserts that the

Secretary's interpretation of the regulation in this case is contrary to its plain meaning, is inconsistent with nearly 20 years of agency practice, and results in absurd reimbursement decisions, which violate the statute's requirement that Medicare pay its fair share of costs of treating Medicare beneficiaries.

In addition, the Secretary's attempt to create an irrebuttable presumption of "community support" from the fact that costs previously were not claimed has no basis in the record, and is contrary to Congressional intent. The Secretary's presumption results in the absurd conclusion that whether a hospital is entitled to be reimbursed for related-party medical school costs depends not on whether there is any evidence of actual community support for the hospital's GME programs, but rather on the fortuity of whether the hospital has previously claimed such costs. Moreover, the Secretary maintained below that "community support" is any source of funding for medical education *other than* the Medicare program. Pet. App. 18a. Such an interpretation is clearly contrary to Congress' expressed intent at the time the Medicare Act was passed. Finally, the specific types of funding the Secretary pointed to in this case as evidence of community support plainly are not the sort of "public and private contributions" intended for the support of graduate medical education programs that Congress contemplated when it referred in the legislative history of the Medicare Act to the "ideal" of community support.

ARGUMENT

I. STANDARD OF REVIEW

On appeal under the Administrative Procedure Act, 5 U.S.C. § 706, this Court must review the administrative record anew and decide all relevant questions of law, interpret constitutional and statutory provisions, and hold unlawful any administrative decision that is arbitrary, capricious, an abuse of

discretion, unsupported by substantial evidence, or otherwise not in accordance with law.

In reviewing agency actions under the arbitrary and capricious standard, the Court must consider "whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971). An agency action is arbitrary and capricious if the agency has "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Similarly, the substantial evidence standard requires an in-depth review of the facts relied upon by the agency in its decision. At a minimum, a decision is not supported by substantial evidence unless the record contains such relevant evidence that a reasonable mind might accept as adequate to support the challenged conclusion. *Airport Shuttle Serv., Inc. v. Interstate Commerce Comm'n*, 676 F.2d 836, 840 (D.C. Cir. 1982).

Although an administrative agency's interpretation of its own regulations is generally entitled to deference, an agency's interpretation is not shielded "from a thorough, probing, in-depth review." *Citizens to Preserve Overton Park*, 401 U.S. at 415. *See also Batterton v. Francis*, 432 U.S. 416, 425 n.9 (1977). As this Court has explained, the existence of prior inconsistent interpretations detracts substantially from the deference normally due an agency's interpretation of its own statute and regulations. *See General Elec. Co. v. Gilbert*, 429 U.S. 125, 141-43 (1976). As the Court recently noted:

> [T]he consistency of an agency's position is a factor in assessing the weight that position is due. As we have stated, "an agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view."

Good Samaritan Hosp. v. Shalala, 124 L. Ed. 2d 368, 382 (1993) (quoting *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446 n.30 (1987) (emphasis added)). *See also Bowen v. American Hosp. Ass'n*, 476 U.S. 610, 646 n.34 (1986) (agency interpretation which has neither been consistent nor longstanding substantially diminishes any deference due).[10] Moreover, "an agency changing its course . . . is obligated to supply a reasoned analysis for the change. . . ." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 42.

II. THE SECRETARY'S INTERPRETATION OF SECTION 413.85(c) IS ARBITRARY, CAPRICIOUS AND UNSUPPORTED BY SUBSTANTIAL EVIDENCE

The Secretary denied the Hospital's claim on the ground that the reimbursement sought constituted redistribution of *costs* from the Medical School to the Hospital. According to the Secretary, since the Hospital had not previously claimed some of the Medical School costs it now claims as GME costs, its reimbursement claim and any similar claim in the future constitutes a prohibited "redistribution." In effect, the Secretary created an irrebuttable presumption that it was a redistribution for the Hospital to claim costs it had not previously claimed. Pet.

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[10] *See also United Transp. Union v. Lewis*, 711 F.2d 233, 242 (D.C. Cir. 1983) ("A statutory construction to which an agency has not consistently adhered is owed no deference."); *Saint Mary of Nazareth Hosp. Ctr. v. Schweiker*, 718 F.2d 459, 464 (D.C. Cir. 1983); *Northwest Hosp., Inc. v. Hospital Serv. Corp.*, 687 F.2d 985, 991 (7th Cir. 1982); *Saint James Hosp. v. Heckler*, 760 F.2d 1460, 1472 (7th Cir.), *cert. denied*, 474 U.S. 902 (1985) ("Although an agency is not rigidly bound to its own precedent, the presumption is against changes in established policy that are not justified by the rulemaking record.").

App. 34a-35a.[11] According to the Secretary, this result is mandated by the portion of section 413.85(c) which provides that:

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The Secretary interprets section 413.85(c) to mean that the *costs* at issue must have been "customarily and traditionally" claimed by a hospital.

A. The Secretary's Interpretation Of The Regulation Is Inconsistent With Its Plain Meaning

The Secretary's interpretation violates the plain meaning of her own regulatory framework. As a reading of the regulation makes clear, and as the courts in *Ohio State University* found, the prohibition against redistribution is contained in a sentence that begins, "the intent of the program is to share in the support of educational *activities* customarily or traditionally carried on by providers. . . ." 42 C.F.R. § 413.85(c) (emphasis added). The clear meaning of this passage is "to allow providers to receive reimbursement for a fair share of all direct and indirect costs related to educational activities customarily or traditionally carried on by providers in conjunction with their operations." *See Ohio State University*, 777 F. Supp. at 587.

Teaching hospitals, such as Petitioner, customarily and traditionally engage in the clinical training of interns and residents in a hospital setting. Indeed, the Hospital has operated

[11] *See also Ohio State University*, 777 F. Supp. at 588 ("The Administrator seems to have concluded that since these costs had not been claimed in prior years, there was an irrebuttable presumption that they represented a redistribution of costs of the medical school to the Provider").

GME programs since well before the inception of the Medicare program. Pet. App. 8a. Educational institutions, on the other hand, customarily and traditionally engage in classroom training, undergraduate medical education, and other non-clinical education activities. As the district court in the *Ohio State University* case recognized:

> In the case of graduate medical education, it would be customary and traditional for a teaching hospital to employ qualified physicians in various medical specialties to select and supervise the interns and residents enrolled in the educational program. These physicians would need clerical and administrative staff, office space and supplies to carry out their function. Their salaries, the salaries of their clerical and administrative staffs, and the cost of their office space and supplies would all be part of the cost of the educational activity which ultimately contributes to the quality of patient care in the hospital. . . . They would be the kind of costs Congress intended that the Medicare program should participate in.

Ohio State University, 777 F. Supp. at 587.

B. The Secretary's Interpretation Is Inconsistent With Her Internal Policies And Previous Application Of The Regulation

That the *Ohio State University* court properly interpreted section 413.85(c) is evidenced by the Secretary's own actions, both with respect to her past treatment of the Hospital and her past and current interpretations of the redistribution language. For example, the Hospital filed its first claim for reimbursement of related-party GME costs in 1974. If the Secretary's current interpretation of section 413.85(c) is correct, of course, that claim was a "redistribution," since, at that time, the Hospital had not "historically" claimed such costs. The Secretary did not deny the Hospital's claim in 1974, nor, prior to the mid-1980s,

did she ever claim that any teaching hospital claiming GME costs for the first time, or simply claiming *increased* costs, was engaged in a "redistribution."

The Secretary's 1974 treatment of Petitioner's request for reimbursement of related-party GME costs was no mere fluke. Indeed, the Secretary's internal operating guidelines issued to provide guidance to teaching hospitals for claiming costs incurred by a related medical school recognizes as "allowable *hospital* costs" the reasonable costs incurred by a related medical school in support of the hospital's GME programs. IL 78-7 (Pet. App. 64a). Nowhere does IL 78-7 suggest that these cost claims must meet the Secretary's redistribution analysis. Nor does IL 78-7 suggest that teaching hospitals can claim as related-party medical school costs only those costs which they have historically claimed. By the time IL 78-7 was issued, the Medicare program had been operating for more than 10 years. If the Secretary's current interpretation of the regulation is correct, IL 78-7 should have instructed intermediaries that any related-party GME costs not previously claimed represented a prohibited redistribution. It did not. It is remarkable that neither the concept of redistribution nor the relevant regulatory section is cited in the Secretary's internal guidelines for the proper treatment of GME costs by teaching hospitals. This absence is persuasive evidence that the Secretary's interpretation of section 413.85(c) is *not* a long-standing or consistent policy, but rather a recently-discovered tool for denying legitimate reimbursement claims.

This conclusion is also supported by the Secretary's past treatment of similarly-situated hospitals. For example, the record demonstrates that between at least 1982 and 1986, HCFA was engaged in correspondence related to the University of Oregon's Health Sciences University's ("Oregon") request for reimbursement of related-party medical school costs incurred in support of the hospital's GME programs. J.A. 22-30. It is clear

that in 1982, those costs had not previously been claimed by the University. In a 1982 memorandum, the HCFA Regional Office requested guidance from the Director of the Office of Reimbursement Policy regarding Oregon's request. J.A. 22-24. The Regional Office noted that there was ambiguity between the redistribution concept expressed in the Provider Reimbursement Manual and IL 78-7 which makes no mention of redistribution. *See* J.A. 23. HCFA responded that "allocation of costs to a hospital from a related medical school is governed by Intermediary Letter 78-7." J.A. 25. The HCFA response did not suggest that GME costs raised any question regarding an impermissible "redistribution," despite the Regional Office's express reference to the redistribution concept. Certainly, the response does not suggest that the hospital's failure to claim these costs prior to 1982 makes the request a "presumptive" redistribution. *See* J.A. 25-26.

In a 1985 memorandum, HCFA disingenuously attempted to "clarify" the 1982 memorandum. J.A. 27 ("The fact that [redistribution] is not mentioned in the subject memorandum does not change the basic policy as espoused in 42 C.F.R. [413.85(c)]."). The failure of the 1982 memorandum to mention redistribution in the context of a specific request for a clarification of the applicability of the redistribution concept in light of IL 78-7, could hardly be characterized as an oversight. Rather, it is powerful proof the agency did not consider a first-time request for reimbursement of related-party GME costs to constitute a redistribution. Moreover, if redistribution had been the agency's policy in 1982, all the advice HCFA supplied with respect to Oregon perfecting its cost claim would have been purely academic. Apparently the 1985 memorandum was later repudiated. Subsequent correspondence from the author of the 1985 memorandum to Oregon discusses the general allowability of related-party medical school costs in a hospital's costs for GME programs again without mentioning either the concept of redistribution or the specific regulation. J.A. 29-30. In any

event, it is clear that the "policy" set forth in the 1985 memorandum was never applied to disallow related-party GME costs claimed *for the first time* by Oregon in 1982-83.[12]

C. The Secretary's Application Of The Redistribution Principle Here Is Inconsistent With Her Recent Treatment Of The Concept In Proposed Regulations

The Secretary's treatment of this Hospital and similarly-situated hospitals is rife with inconsistencies. Aside from these informal memoranda and letters, the best source for the Secretary's actual interpretation and application of the redistribution concept is in the GME regulation itself and the preamble discussions to various modifications of it.

For example, in the Preamble to the 1989 GME Regulation, 54 Fed. Reg. 40286, 40302 (J.A. 43), the Secretary responded to an inquiry about the proposed regulations requesting clarification regarding the "treatment of GME costs of a related medical school," and, specifically, "whether there is a redistribution of GME costs when State appropriations or other funding sources are sufficient to cover the costs of operating the medical

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[12] *See University Hospital & Clinic (Portland, Ore.) v. Blue Cross & Blue Shield Ass'n/Blue Cross & Blue Shield of Oregon*, PRRB Hearing Dec. No. 93-D56, [1993-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 41,605 (July 15, 1993). This case involved the ability of the University of Oregon to be reimbursed for the full amount of faculty physician teaching and administrative costs for fiscal years 1978 through 1981. Prior to fiscal year 1978, the university hospital did not claim Medicare reimbursement for services rendered at the hospital by the medical school's clinical faculty physicians. The PRRB disallowed the costs at issue for fiscal years 1978-1981 based on an application of Medicare's reopening rules, rather than on the redistribution prohibition. In his dissenting opinion, PRRB member Roark stated that the costs of faculty teaching and administrative services had been allowed for fiscal years 1982 and 1983. *Id.* at p. 36,744. Thus, it is evident that the directive in HCFA's correspondence dated December 1985 (J.A. 28) was never implemented or applied to these fiscal years.

school." *Id.* In response, the Secretary stated that "[c]ertain identifiable activities *conducted by the faculty of a related medical school*, which are necessary for the clinical training function at the hospital, may represent allowable costs for Medicare program purposes." *Id.* (emphasis added). The Secretary explained, for example, that costs incurred by a university medical school for office space and clinical support to physicians supervising interns and residents in a hospital's GME program "*may be allowable if it can be demonstrated* to the satisfaction of the fiscal intermediary that such costs are *directly related to the training program of the interns and residents working in the university hospital* and are related to the care and treatment of the hospital's patients." J.A. 44. (emphasis added). In the preamble, the Secretary also specifically authorized hospitals to present information regarding any factors they believe should be taken into consideration in determining their allowable base period GME costs and "to introduce additional GME costs not previously claimed" in connection with the reaudit activity under the amended GME regulations. J.A. 42. The failure of the Secretary, when squarely faced with the issue, to articulate a policy of redistribution in connection with a related-party GME clinical training costs claim, cannot be dismissed as mere inadvertence. Rather, it is clear evidence that she had no such policy.

Finally, in the preamble to proposed regulations relating to nursing education and allied health, 57 Fed. Reg. 43659 (Sept. 22, 1992) (J.A. 45-52]), the Secretary states categorically that the redistribution principle is inapplicable to graduate medical education costs incurred by a related-medical school as provided in IL 78-7:

> The current regulation concerning related organizations at § 413.17 was established to avoid program recognition of artificially inflated costs that might be generated from less than arm's length bargaining.

> This policy was not intended to expand the range of items and services for which a provider could claim payment. With respect to educational costs (*with the limited exception for certain graduate medical education costs incurred by a related medical school as provided in Intermediary Letter 78-7*), our policy has been that the provider, rather than the related organization, must directly incur the costs on its books and records before the costs will be recognized for Medicare payment purposes. Otherwise, the principle that Medicare payment for medical education costs should not result in a redistribution of costs from the educational institution to the provider would be violated.

J.A. 53-54 (emphasis added). This, of course, is precisely the point argued by the Hospital: that the redistribution principle has *never* been applied to GME clinical training costs for which reimbursement is permitted pursuant to IL 78-7.

Obviously, the Secretary's interpretation of her regulation in this case does not represent "long-standing" policy. Rather, the interpretation appears to be newly arrived at, and adopted for the purpose of denying legitimate claims in order to save the program money. Although the Secretary presumably is entitled to consider the costs of her actions, she cannot change a long-standing interpretation of a regulation, without notice or comment, and with no specific Congressional authorization, solely to save the program money. *See Villa View Community Hosp., Inc. v. Heckler*, 720 F.2d 1086, 1094 (9th Cir. 1983). Such action is contrary to the specific statutory direction that hospitals be reimbursed on the basis of their reasonable costs and the requirement that the Secretary's reasonable cost calculation methods shall not result in shifting costs of treating Medicare patients to non-Medicare patients. 42 U.S.C. § 1395x(v)(1)(A).

The Secretary's focus on whether costs have customarily and traditionally been claimed violates the plain meaning of the

regulation and her past practices. Moreover, even assuming that the "customarily or traditionally" test applies to costs as well as activities, what is a customary or traditional cost? Is it a dollar amount; if so, why aren't reasonable and necessary increases reimbursable?[13] Is it a period of time; if so, what number of years of not claiming the cost is sufficient to disqualify all future reimbursement and what number of years of claiming a cost is sufficient to permit future claims for increases in reimbursement?[14] Is it a "type" of expense and, if so, are "types" of expense fixed in perpetuity? As of which year? Is it historical cost accounting, no matter how flawed, out-of-date, or inappropriate? If so, does that permit the Secretary to close her eyes to more current cost studies, which demonstrate that adjustments or refinements to existing cost allocations are more proper, sensitive, and accurate? The Secretary's steadfast refusal to look at the *actual* evidence of the Hospital's true GME costs in favor of a presumption based on historical cost claims is the very essence of arbitrary and capricious agency action. Moreover, the change in her interpretation of the redistribution regulation, with no explanation for the change in policy, is arbitrary and capricious.

The policy of the Medicare Act is clear. Congress sought to provide a system of medical insurance for the aged and disabled. The system designed directs that providers of medical services are to be reimbursed for their reasonable costs of furnishing needed health services to covered beneficiaries. The Secretary's decision here, affirmed by the courts below, that certain costs cannot be reimbursed because they were not

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[13] As noted above, the Medical School's costs increased dramatically between 1974 and 1984. *See* n.5, *supra*.

[14] Recall, it is undisputed that reimbursement was claimed by the Hospital for Medical School costs and allowed by Medicare for the first time in 1974. Pet. App. 8a.

claimed from the inception of the Medicare program, is flatly inconsistent with the basic purpose of the statute.

III. THE SECRETARY'S APPLICATION OF THE "COMMUNITY SUPPORT" LANGUAGE TO DENY THE HOSPITAL'S CLAIM IS ARBITRARY AND CAPRICIOUS

The district court found that "the Secretary views community support as any source of funding other than the Medicare program." Pet. App. 18a. Moreover, the court noted that "[t]he Secretary's decision in this case considered community support to include 'tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware.'" *Id.* The court found this definition reasonable and "entitled to deference." *Id.* The court's determination was based on its conclusion that the Secretary's definition was "consistent with both the American Hospital Association ("AHA") principles as well as the Secretary's earlier applications of the community support principle in the context of disputed claims for reimbursement of GME program costs." *Id.*[15] Significantly, the court never considered whether the Secretary's definition of "community support" was consistent with Congressional intent. Clearly, it is not.

[15] Although the district court found that the Secretary's interpretation of the community support issue was "consistent" with other cases, the only example cited was *University of Minnesota Hospitals & Clinics v. Blue Cross & Blue Shield Ass'n/Blue Cross & Blue Shield of Minnesota*, [1992-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 39,420, at 26,828 (May 29, 1991). Pet. App. 18a. This case is from the same time period as Thomas Jefferson's request. Prior to about 1985, it does not appear that the Secretary had ever denied a claim for GME costs either on the basis that the costs had been "redistributed" from a related medical school to a hospital, or on the ground that the costs had previously been borne by the community.

A. The Secretary's Definition Of "Community Support" Is Inconsistent With Congressional Intent And Previous Agency Policy

The Secretary's current interpretation — that community support is every non-Medicare source of funding — simply makes no sense when examined in the context of the time the statute was written, when all medical education programs were 100 percent supported by non-Medicare funds. It is one thing to find that an agency is entitled to make reasonable interpretations of a statute where the statute is ambiguous or incomplete. *Chevron United States, Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984). It is quite another, however, to allow the Secretary to adopt an interpretation of language which it is simply impossible for Congress to have intended. Such "deference" goes too far.

Moreover, the Secretary's definition is *not* consistent with AHA principles,[16] with the Secretary's earlier application of the

[16] The Secretary relied on the AHA's Cost Reimbursement Guidelines and testimony of an AHA representative at the hearing on the original Medicare Act (J.A. 31) to develop her GME cost reimbursement regulation. *See* Pet. App. 18a; J.A. 47. The AHA Guidelines provide:

> Section 2.302 — In determining reimbursable cost, a reasonable amount for medical, nursing and other education not reimbursed through tuition, or through scholarships, grants, and other community sources is a legitimate inclusion. . . .
>
> COMMENT . . . Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining reimbursable cost of hospital service until the community is prepared to assume this educational responsibility.

J.A. 33.

principle in regard to *this* Hospital, or with her treatment of similarly-situated hospitals. First, the AHA Guidelines as they existed at the start of the Medicare program recognized that charges to sick patients did not constitute community support, and clearly recognized that GME programs were *not* receiving community support. J.A. 33. Thus, not all sources of funding for GME programs then in existence (all of which were non-Medicare) constituted "community support." *Id.* Second, the Secretary's treatment of the Hospital's previous claims demonstrates that her interpretation is not consistent. If the Secretary's current interpretation is correct, the GME costs which the Hospital began to claim in 1974 were borne by the "community" — since they were financed by sources other than Medicare. That the Secretary did not disallow the Hospital's increased GME cost claims in 1974 demonstrates that her current interpretation is not "consistent" with past practice.

This conclusion is further supported by the recent rulemaking activity in this area. In 1992, the Secretary promulgated proposed regulations to amend section 413.85(c). *See* 57 Fed. Reg. 43659 (J.A. 45). In her proposed regulations, the Secretary admits that no criteria previously existed for determining whether there has been "community support" for GME programs. *See* J.A. 51. Her proposed regulation does indeed purport to establish prospectively "community support" from failure to claim a cost in the past. However, if no criteria previously existed, and there was no notice of the Secretary's definition of community support, the Secretary's claim that the Hospital, in effect, voluntarily waived in perpetuity its right to reimbursement for the reasonable costs of its GME programs because it failed to claim those costs at the onset of the Medicare program is arbitrary and capricious.

B. The Secretary's Interpretation Of "Community Support" Is Inconsistent With Her Own Regulations

1. The Secretary Attempts to Give the Language of Subsection (c) Meaning Not Evident on its Face

The Secretary's interpretation of "community support" within the meaning of section 413.85(c) is also inconsistent with the other sections of that regulation. Subsection (c) of the Secretary's regulation stands out from the other subsections of the regulation, and from the Secretary's other Medicare regulations, in that the language used is general, explanatory, almost philosophical. In sharp contrast, the other subsections of section 413.85, as well as the Secretary's other Medicare reimbursement regulations, consist of technical directions or definitions which describe how the Medicare program is to be implemented. In general, the Secretary's cost reimbursement regulations are filled with details regarding the specific types of costs, the methods for measuring costs, and cost accounting principles for allocating overhead costs and apportioning costs to Medicare patients. *See, e.g.*, 42 C.F.R. § 413.94 (value of services of non-paid workers); 42 C.F.R. § 413.134 (determination of depreciation); 42 C.F.R. § 413.53 (overhead allocations); and 42 C.F.R. § 413.50 (apportionment of costs).

Indeed, the other subsections of section 413.85 proceed in this manner. Subsection (a) directs that a provider's costs may include its net cost of approved educational activities. It cross references other regulations and other subsections for further instructions on the calculation of "costs" and "net costs." Subsection (b) defines "approved educational activities" in precise terms, and mandates that such programs must either be licensed or recognized by national professional associations.

Subsection (c), in contrast, starts out with a general policy statement on Medicare support of medical education programs

conducted by hospitals, the first two-thirds of which is taken practically verbatim from the legislative history of the Act. *Compare* 42 C.F.R. § 413.85(c) *with* H.R. Rep. No. 213 (J.A. 31-32), *and* S. Rep. No. 404 (J.A. 32). Rather than providing instructions or definitions, this section repeats Congress' expressions of approval for medical education generally, and its precatory "ideal" of "community support" of such educational activities, which is also articulated in the legislative history. *Id.* Certainly the regulation does not instruct a provider on what community support is, how it is to be measured, or the impact on increased costs of medical education programs relative to levels of community support. Nor does the regulation, on its face, alert a provider to the draconian results of a failure to claim from Medicare the full reasonable costs of GME programs which are the outcome of the Secretary's application of her new interpretation of subsection (c) to this Hospital.

Subsection (g) defines the term "net costs" of approved education programs. These are the costs that the Medicare program will share in. If "community support" were to be factored into the determination of the amount of GME costs Medicare would share in, one would expect to find the subject addressed here. The subject is not addressed. Rather, net costs are defined simply as full costs less tuition. 42 C.F.R. § 413.85(g).

Here, the Secretary identified "tuition, hospital fees, grants, bequests and state funded support from Pennsylvania and Delaware" as the sources of "community support" for the Hospital's GME programs. Pet. App. 32a. Two of these sources — tuition and the state appropriations — clearly support only undergraduate education. Pet. App. 48a. They cannot be deemed support for the Hospital's GME programs. One of the items — hospital fees (*i.e.*, charges to sick patients) — was specifically singled out in the legislative history as *not* constituting community support. *See* J.A. 31, 33. And the final two items — grants and

bequests — are not required to be offset against allowable costs by the Secretary's own regulations, as discussed below.

2. The History of the Definition of "Net Costs" Demonstrates There is No Basis for the Secretary's Current Reading of Community Support

The history of the definition of "net costs" supports Petitioner's argument that the sources of funding identified by the Secretary in her decision below as evidence of "community support" for the Hospital's GME programs do not constitute community support either on the record in this case or under the Secretary's own regulations.

Originally, net costs were calculated by offsetting from full costs "grants, tuition and specific donations." 20 C.F.R. § 405.421(b)(2) (J.A. 34). In 1980, the regulation was amended to preclude the offset of certain specific grants and donations for primary care internships and residency programs. 45 Fed. Reg. 51783, 51786 (Aug. 5, 1980) (J.A. 38-39). Finally, in 1984, the Secretary's regulations were revised to disregard *all* gifts and grants in determining allowable education costs. 49 Fed. Reg. 234, 296 (Jan. 3, 1984) (J.A. 40-41). This revision was designed to make the Secretary's regulation for calculating net costs for purposes of GME reimbursement consistent with her regulations regarding calculating net costs under other Medicare reimbursement regulations. *See Id.*

In explaining why she was exempting gifts and grants from items to be offset against total costs, the Secretary said:

> Since the offset of donor restricted contributions appears to dilute the effect of the contribution, it may discourage private philanthropy. Because we believe it is in the best interests of needed health care to increase private sector support of health care institutions, we are eliminating Sec. 405.423 [which re-

> quired the offset of restricted grants, gifts and income from endowments]. As a result, restricted grants and gifts will no longer be used to offset costs effective with cost reporting periods beginning on or after October 1, 1983.

48 Fed. Reg. 39752, 39797 (Sept. 1, 1983). If "community support" in the GME regulation had the meaning the Secretary now ascribes to it, however, these funds should logically be offset against total cost for purposes of determining allowable GME costs.[17] Yet, the Secretary revised her regulation to eliminate the offset of these costs for purposes of calculating total allowable GME costs. J.A. 39-40. Having eliminated those items from the category of funds which must be deducted from full costs to determine allowable GME costs in subsection (g), the Secretary in effect attempts to read them back into the regulation under the vague "community support" language of subsection (c). Such slight-of-hand rulemaking is arbitrary and capricious. The Secretary cannot change her regulation regarding the treatment of these types of funds by reference to a vague policy that has never previously been defined, with no explanation for the change and without notice or an opportunity to comment on the change.

Finally, the district court found justification for the Secretary's interpretation of "community support" in another Congressional policy — that reflected by the 1983 Amendments to the Social Security Act. According to the district court, interpreting the regulation to allow the Hospital's claim would "plainly conflict" with the purpose of the 1983 revisions, which

[17] Apparently recognizing this inconsistency, the Secretary is considering revising her net cost definition again, to reinstate the offset for "donations, grants and *non-Medicare* public funding from the provider's total allowable costs. . . ." J.A. 54 (emphasis added). The fact remains, however, that during the Hospital's 1985 cost year, grants, donations and other non-Medicare funds were *not* required to be offset from total costs to determine allowable costs.

was to "stem[] the spiraling costs of the Medicare program. . . ." Pet. App. 20a. *See also* Brief for the Respondent on Petition for a Writ of Certiorari, at 6. The 1983 change in Medicare reimbursement cited by the Court did not give the Secretary *carte blanche* to ignore the reasonable cost standards of 42 U.S.C. § 1395x(v)(1)(A) in her reimbursement decisions. On the contrary, the reasonable costs provisions in the Act and regulations as applied to GME programs were not repealed by the 1983 Amendments, and continued to apply in full force to the costs of those programs. There is no principle of statutory or regulatory construction which would allow the Secretary to use one policy change to justify changing a previous interpretation of a regulation and policy that was in the Act before and that specifically was *excluded* by Congress from the change in policy.[18]

In short, there is nothing in the record to support the Secretary's claim that this Hospital was receiving "community support" for its graduate medical education programs. Moreover, the district court's finding that the Secretary's interpretation of this regulation comports with the regulation's "plain meaning" and is entitled to deference because of her long-standing application of the regulation is wrong. The "plain meaning" of community support, as evidenced by the Secretary's past actions in this area, does not support her current interpretation. Finally, the Secretary's interpretation of the regulation has been anything but consistent.

[18] In 1986, Congress did mandate a prospective change to the way Medicare would participate in the costs of GME programs. 42 U.S.C. § 1395ww(h). *See* n.2, *supra*. Congress' revisions to the program arguably reflect a policy determination to try to control the costs of graduate medical education programs. That Congress saw fit to take such action, on a prospective basis in 1986, suggests that its 1983 Amendments do *not* give the Secretary the authority to try to limit Medicare participation in GME costs.

IV. THE DECISION BELOW INTERPRETS SECTION 413.85(c) IN A MANNER INCONSISTENT WITH THE MEDICARE STATUTE

In promulgating the Medicare Act in 1965, Congress made clear its intent that Medicare providers were to be reimbursed, as nearly as possible, for all costs necessarily incurred in the efficient delivery of health care services to Medicare beneficiaries. The Senate Report accompanying the Medicare Act states Congress' explicit intent:

> Although [reimbursement] may be made on various bases, the objective, whatever method of computation is used, will be to approximate as closely as practicable the actual cost (both direct and indirect) of services rendered to the beneficiaries of the program so that under any method of determining costs, the costs of services of individuals covered by the program will not be borne by individuals not covered, and the costs of services of individuals not covered will not be borne by the program.

S. Rep. No. 404, 89th Cong., 1st Sess. 36 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1976. This expression of Congressional purpose is codified in the Act where the Secretary is directed to issue regulations for determining reasonable costs under the Medicare program. 42 U.S.C. § 1395x(v)(1)(A). There, Congress directed that the Secretary's regulations

> *shall* . . . take into account both direct and indirect costs . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare].

Id. (emphasis added).

The result of the Third Circuit's judgment affirming the district court decision here is exactly contrary to Congressional intent: it shifts the costs of providing services to Medicare beneficiaries to individuals not covered by the program. The Secretary's interpretation of the redistribution language was found to result in just this sort of impermissible cost-shifting in *Ohio State University*, 777 F. Supp. at 587 ("If the Medicare program did not pay its fair share of [GME program] costs, there is a likelihood that they would be shifted to non-Medicare patients in violation of the Medicare Act, 42 U.S.C. § 1395x(v)(1)(A). . . ."). The effect of the Secretary's interpretation of the community support language is the same. For whatever fiction she may concoct from the fact that a hospital has not previously claimed GME costs, the fact remains that absent actual community support and reimbursement of its fair share by Medicare, the only alternative for teaching hospitals is to shift the costs of GME programs to non-Medicare patients. The Secretary's mistake in both instances, and the reason her decision is arbitrary and capricious, is that she has failed to examine the actual record (*e.g.*, she ignored the 1985 cost study showing that the Hospital's additional GME costs were actually incurred in providing services to patients and she refused to look at the actual sources of support for those programs) and instead relied on unsupported "presumptions." The result of her approach is to require that reasonable costs actually incurred and *not* supported by the community were shifted to the Hospital's non-Medicare patients. Such a result is contrary to the meaning and purpose of the Medicare Act, and should not be allowed to stand.

CONCLUSION

For the foregoing reasons, Petitioner respectfully prays that the Court reverse the judgment of the Court of Appeals for the Third Circuit, and direct the Secretary to reimburse the Hospital for the reasonable costs incurred in support of its GME programs, in accordance with the findings of the PRRB.

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Dated: February 24, 1994

No. 93-120

In the Supreme Court of the United States

OCTOBER TERM, 1993

THOMAS JEFFERSON UNIVERSITY, D/B/A
THOMAS JEFFERSON UNIVERSITY HOSPITAL, PETITIONER

v.

DONNA E. SHALALA,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Under Medicare regulations, a hospital's "allowable cost[s]," for which reimbursement is available, may include the cost of clinical training programs for interns and residents, known as graduate medical education (GME) programs. 42 C.F.R. 413.85(a). The regulations further provide, however, that reimbursement is available for medical education costs only "[u]ntil communities undertake to bear these costs," and that "it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." 42 C.F.R. 413.85(c).

The question presented is:

Whether the Secretary reasonably determined that 42 C.F.R. 413.85(c) bars petitioner Thomas Jefferson Hospital from obtaining Medicare reimbursement of GME program costs that previously were absorbed by its affiliated medical school.

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BRIEF FOR THE RESPONDENT

OPINIONS BELOW

The order of the court of appeals (Pet. App. 1a-2a) and the opinion of the district court (Pet. App. 3a-25a) are unreported. The judgment of the court of appeals is noted at 993 F.2d 879 (Table).

JURISDICTION

The judgment of the court of appeals was entered on April 21, 1993. Pet. App. 1a. The petition for a writ of certiorari was filed on July 20, 1993, and was granted on January 10, 1994 (114 S. Ct. 680). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

REGULATORY PROVISION INVOLVED

The relevant regulatory provision, 42 C.F.R. 413.85(c), is set forth at J.A. 40-41.

STATEMENT

This case involves the application of a regulation, 42 C.F.R. 413.85(c), that prohibits Medicare reimbursement of increased costs resulting from a "redistribution of costs" of educational activities from a hospital's affiliated educational institution (such as a medical school) to the hospital. The regulation further states that Medicare will reimburse the costs of medical education only "[u]ntil" the community bears them. In this case, the court of appeals held that Section 413.85(c) does not permit petitioner Thomas Jefferson University Hospital to receive Medicare reimbursement for costs incurred in fiscal year 1985 by its affiliated medical school in connection with the Hospital's educational programs for interns and residents, because the medical school had paid those costs in the past.[1]

1. a. Title XVIII of the Social Security Act establishes the federally funded Medicare Program, which provides health insurance for the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the Program provides insurance for inpatient hospital and related post-hospital services.[2] Persons covered by Medicare may receive medical services at any facility participating in the Medicare Program as a

[1] The Sixth Circuit reached a contrary result in *Ohio State University* v. *Secretary, United States Dep't of Health & Human Services*, 996 F.2d 122 (6th Cir. 1993), petition for cert. pending, No. 93-696 (filed Nov. 1, 1993).

[2] There also is a voluntary supplementary insurance program (Part B), which covers physicians' charges and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s).

"provider of services." 42 U.S.C. 1395d, 1395x(u). Providers generally are reimbursed for their "reasonable" and "necessary" costs of providing medical services to eligible beneficiaries. 42 U.S.C. 1395x(v)(1)(A); 42 C.F.R. 413.9(b). The "reasonable cost" of services is to be determined in accordance with regulations, issued by the Secretary of Health and Human Services, that establish the "method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions * * * and services." 42 U.S.C. 1395x(v)(1)(A). In prescribing the regulations, the Secretary is to consider, among other things, "the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment * * * to providers of services." *Ibid.*; see also 42 U.S.C. 1395hh (general authorization of regulations).

Under implementing regulations, certain costs of educational programs for health professional trainees, such as nurses, paramedical personnel, physician's assistants, and interns and residents, may be "allowable cost[s]" for which a hospital is able to receive reimbursement under Medicare Part A. 42 C.F.R. 413.85(a). Included in that category are in-hospital clinical training programs for post-graduate physicians, known as graduate medical education (GME) programs. To be eligible for reimbursement, the claimed costs must be for educational services that are "related to the care of [Medicare] beneficiaries." 42 C.F.R. 413.9(a).[3]

[3] Reimbursement is available not only for services furnished by the hospital, but also for services furnished by the hospital's affiliated medical school in connection with the hospital's educational programs. However, the amount of reimbursement is limited in those circumstances by the general "related organizations" regulation, which provides that "costs applicable to services * * * furnished to the provider by organizations related to the provider by common ownership

Reimbursement is also subject to two additional conditions. First, 42 C.F.R. 413.85(c) provides that "[a]lthough the intent of the [Medicare Program] is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." This is known as the "anti-redistribution" principle. Second, 42 C.F.R. 413.85(c) states that the costs of educational activities "should be borne by the community," but that "[u]ntil communities undertake to bear these costs, the [Medicare Program] will participate appropriately in the support of these activities." This is known as the "community support" principle; it independently bars reimbursement of costs that have in the past been paid out of private and public sources of funds other than Medicare.

b. In 1983, Congress changed the method of reimbursement for inpatient services by instituting the Prospective Payment System (PPS), which establishes fixed payment rates for various inpatient services. See 42 U.S.C. 1395ww (d), as added by Pub. L. No. 98-21, § 601(e), 97 Stat. 152-158 (1983). But Congress retained the "reasonable cost" reimbursement system for certain costs, including those of medical education. 42 C.F.R. 1395ww(a)(4). Thus, costs incurred in connection with GME programs were excluded from the PPS scheme, and continued to be reimbursed on a retrospective, "reasonable cost" basis. Pet. App. 5a-6a.

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or control are includable in the allowable cost of the provider at the cost to the related organization." 42 C.F.R. 413.17(a). In addition, as explained in the text, *infra*, reimbursement is further conditioned in the present context on compliance with the "anti-redistribution" and "community support" principles in the regulation (42 U.S.C. 413.85) that specifically governs reimbursement of educational activities.

In 1986, however, Congress adopted a new payment methodology for some of providers' approved educational expenses, effective for cost-reporting years beginning on or after July 1, 1985. Subject to appropriate updating, the calculation of GME costs to be reimbursed in all subsequent years is based on the amount of costs claimed by the provider for a fiscal year beginning between October 1, 1983, and September 30, 1984 (the base year). See Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Pub. L. No. 99-272, § 9202(a), 100 Stat. 171 (1986), codified at 42 U.S.C. 1395ww(h); 42 C.F.R. 413.86(e)(1)(i)(A).[4] The base year coincides with petitioner Thomas

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[4] The COBRA of 1985 distinguishes between "direct graduate medical education costs," which are reimbursed through the "base year" methodology in 42 U.S.C. 1395ww(h), and "indirect costs" associated with post-graduate training programs, which are covered by a separate section enacted by the COBRA of 1985 (see 42 U.S.C. 1395ww(d)(5)(B)) and which are reimbursed through the PPS system applicable to direct patient services. In explaining the difference between the two types of costs under preexisting law, the Conference Report on the COBRA of 1985 stated:

> The medicare program provides reimbursement for both the direct and indirect costs of medical education incurred by teaching hospitals. The direct costs of approved medical education programs (such as salaries for residents and teachers and classroom costs) are excluded from the prospective payment system, and are reimbursed on a reasonable cost basis. The indirect costs are increased patient care costs associated with teaching programs due to such factors as increased diagnostic testing, increased numbers of procedures prescribed, higher staffing ratios, and a more severely ill patient population.

H.R. Conf. Rep. No. 453, 99th Cong., 1st Sess. 455 (1985); see also *id.* at 86-87, 455-458 (describing changes in law related to indirect costs); *id.* at 102-106, 481-487 (describing changes related to direct costs). Under the quoted description, all costs attributable to the operation of a provider's educational programs (including overhead and costs incurred by an affiliated medical school) are "direct" costs to

Jefferson University Hospital's 1985 fiscal year (July 1, 1984-June 30, 1985). See American Hospital Ass'n *et al.* Amicus Br. (AHA Br.) at 5. Thus, the amount of reimbursement allowed to petitioner for GME costs during the period at issue in this case will determine its level of reimbursement for GME programs in all years to come.

2. Thomas Jefferson University Hospital (the Hospital) is a teaching hospital operated by petitioner Thomas Jefferson University, a private not-for-profit educational institution. The Hospital operates Medicare-approved graduate medical education (GME) programs for interns and residents. The GME programs are conducted in the Hospital by faculty of the University's College of Medicine (the Medical School). At the Medicare Program's inception in 1966, the Hospital became an approved provider. Since 1974, the Hospital has received Medicare reimbursement for certain categories of costs related to its GME programs. Between 1974 and 1983, the Hospital obtained reimbursement for salaries it paid to Medical School faculty (or to the Medical School itself) for GME-related services rendered by the faculty in the Hospital. The Hospital also claimed reimbursement for salaries it paid to residents. Pet. App. 8a-9a.

In 1985, the Hospital commissioned an accounting firm to conduct a cost study on which to base its reimbursement claim for fiscal year 1985.[5] Anticipating the results of the

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be reimbursed through the base-year methodology in 42 U.S.C. 1395ww(h), notwithstanding the occasional references by the parties and in the proceedings below to "indirect costs."

[5] A prior review by the Hospital led to a claim for clerical and office space costs in 1984, which the intermediary mistakenly allowed. The intermediary realized its error during the PRRB hearing on the Hospital's claim for fiscal year 1985, but by that time the period during which the intermediary could reopen the Hospital's 1984 cost

not-yet-completed study, the Hospital made adjustments to its 1985 cost report to include additional amounts it estimated would be supported by that study. Specifically, the Hospital increased its claim for resident and intern costs by $4,000,000 (from the $4,737,219 already included for GME costs to $8,737,219). The Hospital also increased the amount it claimed for physician administrative costs by $452,000 (to $2,032,380) to claim expenses for which it had not previously sought reimbursement under Medicare—overhead costs incurred by the Medical School for space, equipment, and general clerical and administrative services in support of the Hospital's GME programs. Pet. App. 9a-10a, 32a, 41a; Pet. C.A. App. 88. After completion of the cost study, the Hospital modified its 1985 cost report to claim $6,614,724 in GME costs and $2,191,481 in general administrative costs. The intermediary allowed $4,183,480 in GME costs (later increased by settlement to $4,635,633) and $1,761,478 in physician administrative costs. Pet. App. 10a, 41a-42a. The intermediary allowed only the costs it initially had determined to be allowable—*i.e.*, those salary and overhead costs that had been claimed in prior years, increased by an inflation factor. It denied the additional increases proposed by the Hospital as an improper attempt to redistribute costs from an educational unit to a patient care unit, in violation of 42 C.F.R. 413.85(c). Pet. App. 9a-10a.[6]

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report under 42 C.F.R. 405.1885 had expired. See Pet. App. 9a & n.3, 35a n.10. The additional costs mistakenly allowed for fiscal year 1984 are not at issue here.

[6] According to petitioner's calculation (Pet. Br. 11-12 & n.7), the settlement (see J.A. 2) left $1,979,091 of costs in dispute. Because approximately 35% of the Hospital's allowable costs were paid by Medicare in fiscal year 1985 (apportioned based on usage of the Hospital by Medicare patients), Medicare would be required to pay petitioner approximately $700,000 if the Secretary were required to allow the additional $1,979,091. See Pet. Br. 12 & n.8.

3. The Hospital appealed to the Provider Reimbursement Review Board (PRRB), which reversed the intermediary's decision and allowed reimbursement of the full costs shown in the cost study. Pet. App. 38a-60a; see 42 U.S.C. 1395*oo*(a). The PRRB noted that the term "redistribution" in 42 C.F.R. 413.85(c) had not been defined in the regulations or in other program instructions, and that it is prefaced in 42 C.F.R. 413.85(c) by a statement that the Medicare Program will share in the support of educational activities customarily or traditionally carried on by providers. For that reason, and "[i]n the absence of further clarification," the PRRB believed that "the focus of the regulation with respect to redistribution is on educational 'activities,' and not the 'cost' associated with the activity." Pet. App. 59a. "Accordingly," the PRRB concluded, "the concept of redistribution would not apply unless the educational program was a new activity being performed by the provider." *Ibid.* The PRRB held that there was no redistribution in this case because "the Provider is merely claiming additional support costs for the GME programs it has historically operated," based on a "refinement of its methodology for determining GME costs." *Ibid.*

4. The Acting Administrator of the Health Care Financing Administration (on behalf of the Secretary) modified the PRRB's decision. Pet. App. 28a-37a; see 42 U.S.C. 1395*oo*(f)(1). He initially observed that upon implementation of PPS and the corresponding provision for pass-through of medical education costs under the "reasonable cost" standard, it "became apparent" that some teaching hospitals "were attempting to claim costs not previously the responsibility of the Provider or reimbursed by Medicare." Pet. App. 34a. Under "established Medicare policy," the Acting Administrator explained, that practice constitutes "an improper redistribution of teaching institution costs to hospital medical education costs." *Ibid.*

Similarly in this case, the Acting Administrator concluded that "[t]he Provider has attempted to radically expand the types of costs claimed * * * for educational activities." Pet. App. 35a. He recognized that Congress intended that, "until the community undertakes to bear such education costs in some way, the Medicare program should bear some portion of the costs of educational activities as an element in the costs of patients care." *Ibid.* But here, he explained (*ibid.*):

> Evidence in the record shows that these cost[s] have been historically borne by the community. The Medicare program was enacted to provide a hospital insurance and basic protection against the costs of hospital care for the aged, and not intended to subsidize medical education programs already supported by the community.

Against this background, the Acting Administrator concluded that the PRRB "improperly determined that the Provider's failure to claim [the disputed] costs in an earlier cost year was an 'error', which it was just attempting to correct"; in his view, that failure should be considered "evidence of the communit[y's] support for these activities." Pet. App. 35a. "To allow the community to withdraw that support and pass these costs to the Medicare program would result in a redistribution of costs in violation of 42 CFR 413.85(c)," which is "precise[ly] [what] Congress intended to prevent." Pet. App. 35a.[7]

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[7] The Acting Administrator further concluded that, despite petitioner's reliance on the "related organizations" principle in 42 C.F.R. 413.17 (see note 3, *supra*), the general and administrative costs of the Medical School would not in any event be allowable medical education costs. The Acting Administrator explained that "the purpose of the related organization principle is to avoid the payment of a profit factor to the provider through a related organization and to avoid payment of artificially inflated costs which may be generated from less

4. The district court sustained the Secretary's decision. Pet. App. 3a-25a. "Adopting a plain meaning approach," it agreed with the Secretary that to qualify for reimbursement, costs of educational activities must satisfy two criteria under 42 C.F.R. 413.85(c): (a) they must "have not been borne traditionally by the community," and (b) they must "have not been redistributed from an educational institution to a patient care unit." Pet. App. 15a. In the court's view, the Secretary properly found that the Hospital had run afoul of both criteria.[8]

a. The district court noted that the regulation does not define "community support," and it found "reasonable

than arms-length bargaining"; it "does not expand items or services allowable under Medicare principles." Pet. App. 36a.

The district court, in sustaining the Acting Administrator's decision, agreed with his conclusion on this point. The court accepted the Secretary's explanation that 42 C.F.R. 413.17 "is a general regulation applied at the threshold to all costs incurred by a related organization in delivering patient care," and that costs still must meet more specific requirements elsewhere in the regulations, such as those in 42 C.F.R. 413.85(c) that govern educational activities. Pet. App. 23a. The court also explained that "[a]pplication of the related organization principle in the manner urged by the Hospital would render the [anti-] redistribution principle almost completely meaningless, a result in conflict with the most basic rules of statutory construction as well as commonsense." *Id.* at 24a. Petitioner does not raise the related organization issue in this Court. See Pet. i; Pet. Br. i.

[8] As a threshold matter, the court rejected, as "in conflict with the plain language" of 42 C.F.R. 413.85(c), the Hospital's argument that the community support and anti-redistribution principles apply "only to the academic or 'classroom' portions of the Hospital's training programs and not to clinical training programs." Pet. App. 16a. The court pointed out that the training of interns and residents "is predominantly, if not exclusively, clinical in nature," and that "[t]he regulation simply contains no language evidencing an intent to distinguish between academic and clinical training for purposes of determining the allowability of costs claimed." *Id.* at 16a-17a.

and entitled to deference" the interpretation in the Acting Administrator's decision that community support includes "tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware," Pet. App. 18a (quoting *id.* at 32a). The court found that definition consistent both with the position the Secretary had taken in other cases involving disputed claims for GME costs, and with reimbursement principles adopted by the American Hospital Association. *Id.* at 18a. The court next held that the Secretary's finding that the increased GME costs claimed by petitioner for fiscal year 1985 had traditionally been borne by the community was supported by substantial evidence. *Id.* at 19a. It pointed to testimony before the PRRB establishing that the costs had previously been borne by the Medical School and that the ultimate sources of funding included "appropriations from the Commonwealth of Pennsylvania and the State of Delaware as well as gifts, grants and alumni giving endowments." *Ibid.*

The court rejected the suggestion that a provider may look to Medicare for increased support when community support decreases. Pet. App. 19a-20a. In the court's view, the regulation's language "evidences Congress' express intent" that the community should bear the costs of medical education programs and that Medicare would "participate appropriately in the support of these activities" only "*until* [ ] communities undertake to bear these costs." *Id.* at 20a (quoting 42 C.F.R. 413.85(c) (emphasis added by the court)). "Nothing in the regulation suggests * * * that a provider may seek to compensate for a decline in community support by escalating costs claimed from the Medicare program." Pet. App. 20a. The court also explained that petitioner's interpretation would conflict with the purpose of the 1983 amendments to the Medicare program of "stemming the spiraling costs of the Medicare program to prevent exhaustion of the fund and achieving a level of budget neutrality." *Ibid.*

b. On the issue of redistribution, the court first rejected petitioner's position "that the [anti-]redistribution principle operates to prohibit only the impermissible shifting of 'activities' from an educational unit to a patient care unit and does not apply to the shifting of 'costs' for activities customarily and traditionally carried on [by] the provider." Pet. App. 21a. The court instead "concur[red] with the Secretary's conclusion that the regulation admits of only one interpretation, to wit, if the costs of activities customarily and traditionally carried on by providers in conjunction with their operations have been absorbed by an educational unit, such costs may not later be redistributed to a patient care unit." *Id.* at 21a-22a. The court further found the Secretary's application of the regulation here to be "consistent with earlier applications in other disputes concerning the proper level of reimbursement for educational activities." *Id.* at 22a. "It is uncontroverted," the court noted, "that the excess costs claimed by the Hospital in fiscal year 1985 previously were borne by the Medical School." *Ibid.* Thus, "despite careful consideration of the Hospital's assertion that its increased claim represented a refinement of its cost-finding techniques rather than a redistribution of costs," the court "agree[d] with the Secretary's conclusion that the increased claim for reimbursement represents an impermissible redistribution of costs from an educational institution, the Medical School, to a patient care institution, the Hospital." *Ibid.*

5. The court of appeals affirmed, on the briefs, without opinion. Pet. App. 1a-2a.

SUMMARY OF ARGUMENT

A. In promulgating 42 C.F.R. 413.85(c), the Secretary of Health and Human Services exercised express statutory authority to determine what shall be considered the "reasonable cost" of delivering patient care services to Medicare beneficiaries. Although Congress recognized that educational activities enhance the quality of medical care in provider institutions, it intended, at the Program's inception, that Medicare should bear the cost of these activities only "until the community undertakes to bear such education costs." S. Rep. No. 404, 89th Cong., 1st Sess. Pt. 1, at 36 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965).

In accordance with Congress's intent, the Secretary has fashioned and interpreted 42 C.F.R. 413.85(c) to establish a general "community support" principle that bars reimbursement of costs incurred in connection with a provider's educational programs if those costs have previously been paid by the community. In a case such as this one, in which a provider's affiliated medical school has in the past furnished support for the provider's educational program (and the provider has not previously claimed Medicare reimbursement for those costs), the community support principle bars Medicare reimbursement of those costs. The Secretary's interpretation of the anti-redistribution clause of the regulation reinforces the community support principle. Under that clause, any attempt to pass on to Medicare costs that have previously been paid by a medical school is a forbidden "redistribution of costs" from an educational unit to a patient care unit. The regulation thus furthers Congress's intent that the community should be the preferred source of support for hospital educational programs and that Medicare should be a payor of last resort.

B. The Secretary's interpretation of 42 C.F.R. 413.85(c) is, at the very least, a reasonable construction of the language of the regulation itself. First, the regulation contemplates Medicare reimbursement of educational costs only "[u]ntil" the community bears the costs, and in this case the community, through the Medical School,

already paid the costs at issue. Second, the final clause of 42 C.F.R. 413.85(c) states that, although Medicare will make reimbursement for some medical education costs, "it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units." Although petitioner asserts that this clause does not apply to clinical training activities at all, the text of the regulation contradicts that view; it speaks of "costs," not "activities," and the term "costs" is used unconditionally. Thus, nothing in the anti-redistribution clause suggests any exclusion of clinical activities, including the clinical GME programs at issue here, from the anti-redistribution principle. Only new or unprecedented costs incurred by a medical school in connection with a provider's GME programs may be reimbursed.

C. The Secretary's construction of 42 C.F.R. 413.85(c) does not lead to arbitrary results that are incompatible with the text and purpose of the Medicare Act. Section 1395x(v)(1)(A) of the Act confers broad authority on the Secretary to determine the "reasonable cost" of reimbursable medical services, and to determine the "items to be included" in such costs. The existence of outside sources of funding for educational activities is relevant to the Secretary's determination of the "reasonableness" of Medicare's payment for the same activities. Although the training received by interns and residents may benefit patients, Medicare's basic purpose is to pay for direct medical services to patients, not to fund medical education. The Secretary may choose to give effect to the basic purpose of the Program by making Medicare the payor of last resort for educational activities, and by placing principal funding responsibility elsewhere, *i.e.*, on the "community." Once outside funds have been made available

to support educational programs, it is within the Secretary's discretion to decide that support from Medicare is not needed to ensure that the provider will continue to carry on its educational activities, and that limited Medicare funds would best be applied elsewhere.

D. The materials cited by petitioner and its amici lend no support to the argument that the Secretary has previously applied 42 C.F.R. 413.85(c) in a manner inconsistent with her position in this case. Indeed, most of those documents—which include internal operating guidelines issued by the Heath Care Financing Administration (HCFA), internal HCFA memoranda, and agency responses to public comments concerning various proposed regulations—did not even discuss the anti-redistribution principle. For the most part, they addressed other aspects of reimbursement of medical education costs. The fact that the Secretary did not discuss the regulation on a particular occasion (or in response to an inquiry directed to another subject) does not change the basic policy as espoused in 42 C.F.R. 413.85(c), nor can a contrary policy be inferred from such silence.

ARGUMENT

UNDER 42 C.F.R. 413.85(c), PETITIONER IS NOT ENTITLED TO MEDICARE REIMBURSEMENT FOR THE COSTS OF ITS GRADUATE MEDICAL EDUCATION PROGRAMS THAT WERE PREVIOUSLY ABSORBED BY ITS AFFILIATED MEDICAL SCHOOL

A. Reimbursement Of Such Costs Would Violate The "Anti-Redistribution" And "Community Support" Principles Under The Secretary's Interpretation of 42 C.F.R. 413.85(c)

When he promulgated the educational activities regulation at the inception of the Medicare Program, the Secretary exercised his express statutory authority to adopt

regulations for determining what shall be considered the "reasonable cost" of delivering patient care services to Medicare beneficiaries, as well as what items shall "be included[ ] in determining such costs." See 42 U.S.C. 1395x(v)(1) (1970).[9] As the Secretary recognized, Congress did not intend that Medicare should bear, as part of the "reasonable cost" of patient services, the full expense of educational activities undertaken by hospitals and other providers. The Senate and House Committee Reports on the Medicare Act contemplated a more measured approach:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

S. Rep. No. 404, 89th Cong., 1st Sess. Pt. 1, at 36 (1965) (J.A. 32); H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965) (J.A. 31-32).

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[9] The regulation was first issued on November 22, 1966 (see J.A. 34) and was designated 20 C.F.R. 405.421 (1967). In 1977, the regulation was recodified at 42 C.F.R. 405.421 (1977). See 42 Fed. Reg. 52,826. It was recodified at 42 C.F.R. 413.85 in 1986. 51 Fed. Reg. 34,790, 34,813. On September 22, 1992, the Secretary published proposed revisions of 42 C.F.R. 413.85 (see 57 Fed. Reg. 43,659-43,673 (J.A. 45)), but those revisions have not yet been adopted in final form.

The Medicare regulation governing the reimbursement of providers' educational activities, 42 C.F.R. 413.85, as interpreted and applied by the Secretary, implements this congressional intent. In subsections (a) and (g) of 42 C.F.R. 413.85, the Secretary has prescribed a method for calculating the "net cost of approved educational activities" that may be included in a provider's allowable costs. Subsection (c) makes clear, however, that "the costs of such educational activities should be borne by the community." Thus, reimbursement of net costs of educational activities is subject to the further condition that Medicare will "participate appropriately in the support of these activities" only "[u]ntil communities undertake to bear these costs." Finally, the regulation states that "it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units."

The Secretary interprets 42 C.F.R. 413.85(c) to establish a broad "community support" principle that bars reimbursement of costs incurred in connection with a provider's educational programs if those costs have previously been paid by the community. Under the regulation, it is only *until* a provider's education costs are funded out of other public and private sources that Medicare will provide funds to pay such costs. That limitation is consistent with the expectation of Congress that "a part of the net cost of [educational] activities * * * should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program," only "*until* the community undertakes to bear such education costs in some other way." S. Rep. No. 404, *supra,* Pt. 1, at 36 (emphasis added); H.R. Rep. No. 213, *supra,* at 32 (emphasis added). Because Medicare, as third-party payor, assumes responsibility only until such time as the community undertakes support (and not thereafter), it

follows that, if educational costs have historically been paid by the community, Medicare will not thereafter assume the burden of paying them. That rule forecloses resort to Medicare if the level of community support that was once available is subsequently reduced. It thereby avoids any incentive for the community to withdraw its support (and for the provider or its affiliated medical school to reduce their efforts to obtain such support), and to shift the costs to Medicare.

In implementing the community support principle in a case such as this, the Secretary in effect presumes that, if costs for educational programs have been incurred in the past by an affiliated educational institution and have not previously been charged by the provider to Medicare, the costs have instead been paid by the affiliated educational institution out of other sources of funding in the community.[10] The sources of funding upon which medical schools ordinarily draw—tuition, grants, gifts, and donations—are considered by the Secretary to qualify as "community support." See, *e.g.*, *Board of Trustees* v. *Sullivan*, 763 F. Supp. 178, 189-191 (S.D. Miss. 1991) (accepting Secretary's position that provider's costs for nursing education are not reimbursable when "State appropriations, along with tuition revenues and grants," have in the past "fully provided for the entire expenses of the School of Nursing").

The Secretary's interpretation of the "anti-redistribution" clause of the regulation reinforces the community support principle. It focuses on a common form of community support for a provider's educational activities: the

[10] That presumption also applies (absent evidence to the contrary) to costs incurred in the past by the provider itself, but not previously charged by it to Medicare. The application of a presumption of "community support" in that setting is not at issue in this case.

payment of some costs associated with a provider's educational programs by that provider's affiliated medical school. Under the anti-redistribution clause, any attempt to pass on to Medicare costs that have previously been paid by a medical school, even if incurred in connection with the provider's clinical education activities, would be forbidden as a "redistribution of costs" from an educational unit to a patient care unit. The result, in a sense, is to consider financial support by an affiliated medical school for any aspect of the provider's educational programs as a form of "community support."[11] It therefore furthers Congress's intent when it established the Medicare Program that the community is the preferred source of support for educational programs in hospitals and that Medicare should be a payor of last resort.

The Secretary's approach is consistent with the background of the Medicare Program in another respect as well. Section 1395x(v)(1)(A) requires the Secretary, in prescribing reimbursement regulations, to "consider * * * the principles generally applied by national organizations." 42 U.S.C. 1395x(v)(1)(A). Pursuant to that statutory directive, Social Security Commissioner Ball stated during hearings on the original Medicare legislation that he would generally "expect to follow" the "principles of payment for hospital care" set forth in a 17-page pamphlet produced by the American Hospital Association (AHA). See *Medical Care for the Aged: Executive Hearings Before the House*

[11] Viewed from that perspective, the anti-redistribution language serves to clarify that although the general "related organizations" regulation (42 C.F.R. 413.17) might otherwise permit a provider to "pass through" to Medicare the costs incurred by an affiliated medical school in support of the provider's educational programs, a medical school will nevertheless be regarded as part of the "community" for purposes of 42 C.F.R. 413.85(c), so that payment of costs by a medical school will be regarded as a form of "community support."

Comm. on Ways and Means, 89th Cong., 1st Sess. Pt. 1, at 142 (1965); see AHA, *Principles of Payment for Hospital Care* (rev. Aug. 1963) (*excerpted at* J.A. 33). Commissioner Ball further stated that Medicare "would be following" the AHA's *Principles of Payment for Hospital Care* as they related to "teaching and nursing education costs." *Executive Hearings, supra*, at 784.

Section 2.302 of the AHA's *Principles of Payment for Hospital Care* stated that "[i]deally, the cost of educating and training" health service personnel "should be financed by the whole community through a combination of public resources and private contributions." See J.A. 33. Section 2.302 went on to state that, although it "will be necessary" that the cost of educational programs be "considered as a factor in determining reimbursement cost [*sic*] of hospital service until the community is prepared to assume this educational responsibility," hospitals and third-party purchasers "must seek methods for transferring this cost to the whole community through concerted joint effort." *Ibid.* The AHA therefore recommended (in language echoed in the committee reports on the Medicare Act) that educational costs be "considered as a factor in determining reimbursement cost [*sic*] of hospital service" by a third-party payor (such as Medicare) "until the community is prepared to assume this educational responsibility." *Ibid.* The "anti-redistribution" and "community support" principles in 42 C.F.R. 413.85(c), as interpreted and applied by the Secretary, conform to the AHA's suggested approach.

B. The Secretary's Interpretation Of The Anti-Redistribution And Community Support Language Of 42 C.F.R. 413.85(c) Is Reasonable And Entitled To Deference

The educational activities regulation, as interpreted by the Secretary, requires rejection of petitioner Hospital's claim for reimbursement under Medicare for the medical education costs at issue here, since "[i]t is uncontroverted that the excess costs claimed by the Hospital in fiscal year 1985 previously were borne by the Medical School." Pet. App. 22a. Petitioner contends that the Secretary's interpretation of her own regulation is erroneous. That contention is without merit.

As previously noted, the Secretary has an explicit mandate to formulate regulations to define what reimbursement is due under the Medicare program. 42 U.S.C. 1395hh, 1395x(v)(1)(A). In view of that mandate, her regulations giving content to the statutory scheme may be set aside only if they are arbitrary, capricious or manifestly contrary to the Act. *Sullivan* v. *Zebley*, 493 U.S. 521, 528 (1990) (quoting *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843-844 (1984)); see *Batterton* v. *Francis*, 432 U.S. 416, 424-426 (1977).

Furthermore, it is axiomatic that the Secretary must be accorded the broadest possible discretion in interpreting the implementing regulations. See *Udall* v. *Tallman*, 380 U.S. 1, 16 (1965) ("[w]hen the construction of an administrative regulation rather than a statute is in issue, deference is even more clearly in order"). The administrative interpretation must be given "controlling weight unless it is plainly erroneous or inconsistent with the regulation." *Id.* at 16-17 (quoting *Bowles* v. *Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)); see *Martin* v. *OSHRC*, 499 U.S. 144, 150-151 (1991); *Robertson* v. *Methow Valley Citizens Council*, 490 U.S. 332, 359

(1989). The Court has been "properly hesitant to substitute an alternative reading for the Secretary's unless that alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation." *Gardebring* v. *Jenkins*, 485 U.S. 415, 430 (1988). Deference is all the more warranted where, as here, the question of interpretation arises under "a complex and highly technical regulatory program," in which the identification and classification of relevant criteria "require significant expertise, and entail the exercise of judgment grounded in policy concerns." *Pauley* v. *BethEnergy Mines, Inc.*, 111 S. Ct. 2524, 2534 (1991).[12]

The Secretary's interpretation of 42 C.F.R. 413.85(c) is, at the very least, a reasonable construction of the language of the regulation itself. In fact, the district court concluded that the Secretary's interpretation is not merely one of several permissible readings, but the only reasonable one. See Pet. App. 21a-22a (agreeing with the Secretary that "the regulation admits of *only one* interpretation" (emphasis added)). In particular, the final clause of 42 C.F.R. 413.85(c) states that, although Medicare will make reimbursement for some medical education costs, "it is not intended that [the Medicare Program] should participate in increased costs resulting from redistribution of costs from

[12] The courts of appeals uniformly have recognized that deference to the Secretary's interpretations of regulations implementing Medicare's complex reimbursement scheme is particularly appropriate. See, *e.g.*, *University of Cincinnati* v. *Heckler*, 733 F.2d 1171, 1173-1174 (6th Cir. 1984) (deference should be accorded "especially in areas like Medicare reimbursements"); *Butler County Memorial Hosp.* v. *Heckler*, 780 F.2d 352, 356 (3d Cir. 1985) ("deference is especially appropriate"); *Abbott-Northwestern Hosp., Inc.* v. *Schweiker*, 698 F.2d 336, 340 (8th Cir. 1983) (same); *Cheshire Hosp.* v. *New Hampshire-Vermont Hosp. Serv., Inc.*, 689 F.2d 1112, 1117 (1st Cir. 1982) (same).

educational institutions or units to patient care institutions or units." Yet that is precisely what petitioner seeks to accomplish here. Moreover, the regulation states that Medicare will in any event support educational activities only "[u]ntil communities undertake to bear these costs"; the community has already borne the costs at issue here through the non-Medicare resources at the Medical School's disposal. In this respect as well, the text of 42 C.F.R. 413.85(c) forecloses petitioner's contention that it may insist that Medicare now bear that burden.

Although petitioner launches a sustained attack on the Secretary's interpretation of the "community support" language, it fails to provide any alternative explanation of how the community support principle should be applied. Petitioner does not describe the circumstances in which communities will be regarded as bearing the costs of educational activities, so that Medicare will have no obligation to do so. Because it is difficult to conceive of an alternative reading of the regulation's community support and anti-redistribution language that would permit the reimbursement of the disputed costs in this case, it is not surprising that petitioner and its amici essentially ignore the clear language of the regulation.[13]

[13] Rather than supplying an alternative reading of the text of 42 C.F.R. 413.85(c), both the Hospital and its amici suggest that it is merely "precatory and advisory" and thus lacks any independent force. See Pet. Br. 31-32 (suggesting that the regulation establishes a "precatory 'ideal' "); AHA Br. 12, 14-15. The key passages in the regulation, however, set forth specific conditions on Medicare funding: educational costs will only be paid "*[u]ntil* communities undertake to bear these costs" (emphasis added), and the "redistribution of costs" from educational institutions to patient care institutions does not trigger an entitlement to reimbursement. Those phrases quite precisely limit the circumstances under which Medicare reimbursement will be made available to pay the costs of a provider's educational programs.

Petitioner and its amici do assert (Pet. Br. 20-21; AHA Br. 14-17), without support, that the anti-redistribution clause does not apply to costs of clinical training at all, but only to costs of the classroom training provided by educational institutions to the provider's clinical trainees (such as paramedics and nurses) and others (such as medical students). See also *Ohio State University* v. *Secretary, United States Dep't of Health & Human Services*, 996 F.2d 122, 124 (6th Cir. 1993) (*reproduced at* Pet. App. 71a), petition for cert. pending, No. 93-696 (filed Nov. 1, 1993). In other words, the anti-redistribution clause must be construed as selectively affecting only the costs of certain *non*-clinical activities. Because GME trainees (interns and residents) receive no classroom training at the Medical School, the anti-redistribution regulation, as so construed, would have no effect whatsoever on the availability of reimbursement for the Medical School's costs of training them.

The problem with this position is that it rests on a serious distortion of the terms of the regulation itself. As noted above, the regulation speaks of "costs," not "activities." Moreover, the term "costs" is used unconditionally. The proscription against redistribution is not limited to the costs of certain selected activities (classroom instruction) carried on by an educational unit. Nor does the anti-redistribution clause suggest any exclusion from its reach for the costs of any other activities carried on by educational units, such as clinical instruction of the provider's trainees by medical school faculty, or the administration of a hospital's clinical program by medical school personnel. In short, the interpretation of the anti-redistribution clause advanced by petitioner and its amici is far less consistent with the regulation's unqualified language than the Secretary's construction.[14]

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[14] In contending that the anti-redistribution regulation applies solely to non-clinical, classroom costs of training, amici AHA *et al.* rely (Br. 16-17) on Section 404.2 of the Provider Reimbursement Manual (PRM) (see J.A. 56-58), which concerns reimbursement of costs of approved nursing and paramedical education programs. PRM Section 404.2, however, supports the Secretary's interpretation.

To enhance the supply of trained nurses to staff their facility, Medicare providers may either support hospital-based nursing programs or may sponsor such programs in conjunction with affiliated or non-affiliated educational institutions. Unlike GME programs, which typically consist exclusively of clinical training on the provider's premises, nursing programs include both classroom and clinical components. Because the classroom portion of the program contributes to the overall education of the same nurses who participate in the clinical portion, classroom costs are chargeable to Medicare as costs "related to" patient care. See 42 C.F.R. 413.9(a). (In contrast, no classroom expenses incurred at an affiliated medical school would be chargeable to Medicare in connection with a provider's GME program. Interns and residents have already completed their classroom training, often at a non-affiliated institution, before they enroll in a provider's GME program. By the same token, the medical students trained at the provider's affiliated school do not care for patients as part of a provider's GME program, and thus their classroom training also is unrelated to care of the provider's patients.)

PRM Section 404.2 notes that, when the provider operates both portions of a nursing program, both classroom and clinical costs are ordinarily allowable. It further notes that when a non-provider operates the educational program, the clinical training portion generally is conducted in a provider or other health care setting and the costs incurred by the provider for clinical training therefore are allowable; but classroom costs paid by the provider to the educational institution for classroom instruction are allowable only if certain criteria are met, including that the "provider's support does not constitute a redistribution of non-provider costs to the provider." J.A. 56-57. Of particular relevance here, PRM Section 404.2 then states: "If the non-provider reduces its costs due to receiving provider support, such reduction constitutes a redistribution of cost from an education institution to a patient care institution and as such is not an allowable provider cost." J.A. 57. The result petitioner seeks to ac-

Even if that were not so, however, the Secretary's construction is, at the very least, a reasonable one. According

to the Secretary, the regulation covers the redistribution of *any* cost incurred by a medical school in connection with a hospital's educational program, whether that cost relates to the clinical or the classroom portion of training. Although such costs, if allowed, are chargeable to Medicare by the provider under the "related organizations" regulation, 42 C.F.R. 413.17 (see Pet. App. 63a), the availability of reimbursement of those costs is subject to the condition in 42 C.F.R. 413.85(c) that the charge not represent a redistribution of costs from one entity to another. The most natural reading of that language—indeed, the only plausible one—is that a cost *previously* incurred and paid by a medical school cannot be "includable in the allowable cost of the provider." See 42 C.F.R. 413.17(a). Only new or unprecedented costs incurred by a medical school in connection with a provider's GME program may be reimbursed. Thus, for example, if a medical school set up an office to administer a GME program newly established by its provider affiliate, the resulting costs could be passed on to Medicare through a claim by the provider for reimbursement of its overall costs of patient care. Since, in that example, the costs had not previously been borne by the medical school (because they had never

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complish—the redistribution of costs from the Medical School to the Hospital so that the latter can claim them under Medicare—is functionally indistinguishable from the practice condemned in the quoted passage. Contrary to amici's contention (AHA Br. 16-17 & n.9), the fact that this Section of the PRM does not discuss how the anti-redistribution and community support principles affect reimbursement of the *clinical* portion of non-provider operated nursing and paramedic programs does not mean that those principles do not apply to clinical costs as well. The quoted passage states a general rule, with no suggestion that the rule is confined to the redistribution of classroom costs.

before been incurred), charging the costs to Medicare would not be premised on a redistribution of costs from the school to the provider.[15]

Nor is the Secretary's construction in any way inconsistent with other subsections of the same regulation, or with other regulations governing Medicare reimbursement.

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[15] Contrary to petitioner's suggestion (Pet. Br. 25-26), the preamble to recent proposed regulations relating to providers' educational programs (see 57 Fed. Reg. 43,659 (1992) (*excerpted at* J.A. 45-55)) does not "state[ ] categorically" that the anti-redistribution principle in 42 C.F.R. 413.85(c) is "inapplicable to [GME] costs incurred by a related-medical school as provided in [Intermediary Letter No. 78-7 (Feb. 1978)]", discussed at page 32, *infra*. The statement quoted by petitioner concerns the application of the "related organizations" regulation, 42 C.F.R. 413.17, and explains that, with the exception of certain GME costs incurred by affiliated medical schools, educational costs of related organizations must be directly reflected on the accounts of providers before they will be recognized by Medicare. Otherwise, the preamble states, the anti-redistribution principle would be violated. 57 Fed. Reg. 43,668 (1992) (J.A. 53-54). The fact that Medicare will recognize some GME costs reflected on accounts of a related medical school, however, does not mean that it will recognize all of them, or that *no* claim for costs previously incurred by a medical school can ever violate the anti-redistribution clause.

In fact, the proposed regulations include a definition of the phrase "redistribution of costs" that confirms the Secretary's interpretation of 42 C.F.R. 413.85(c). It defines the term as "an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider." 57 Fed. Reg. 43,672 (1992). That definition does not represent any change in policy. The proposed regulations are primarily intended to implement statutory amendments concerning nursing and other paramedical (*i.e.*, non-GME) educational programs, which had never been brought under the "base year" methodology made applicable to GME programs in 1985. See *id.* at 43,660 (J.A. 46). But the proposed amendments otherwise are intended to "restate or clarify • • • current policies governing [educational] costs." *Ibid.* (J.A. 45).

Petitioner and its amici complain that the disallowance of costs that previously were paid by the community (including costs paid by an affiliated medical school) cannot be squared with the evolution of subsection (g) of 42 C.F.R. 413.85, which provides for the offset of certain specific sources of funding in calculating the "net cost" of educational activities eligible for Medicare reimbursement. Although subsection (g) originally provided for an offset for "grants, tuition, and specific donations," it was later revised to eliminate the offset for grants and donations.[16] Petitioner objects that, having "eliminated [grants and donations] from the category of funds which must be deducted from full costs to determine allowable GME costs in subsection (g), the Secretary in effect attempts to read them back into the regulation under vague 'community support' language of subsection (c)." Pet. Br. 34; see also AHA Br. 13.

Subsection (c) does not negate the effect of subsection (g), however, because the "offset" and "community support" provisions each play a distinct and cumulative role in determining a provider's ultimate entitlement to reimbursement. Although both regulations are concerned with the effect of outside sources of funding, subsection (g) calculates "net cost" as a function of the availability of outside funds during the cost reporting period in question. Subsection (c), in contrast, is concerned with whether

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[16] Subsection (g) currently requires the offset of any "revenues from tuition" received by the cost-paying institution. The original version of the regulation required the offset of revenues from "grants, tuition, and specific donations." See 20 C.F.R. 405.421(b)(2) (1967). The regulation was subsequently modified to preclude the offset of grants and donations designated for GME programs in specified categories (45 Fed. Reg. 51,783, 51,786-51,787 (1980)), and, finally, to eliminate the offset of any grants or donations entirely (49 Fed. Reg. 234, 296, 313 (1984)). See AHA Br. 12-13; Pet. Br. 33.

costs have historically been paid from sources other than Medicare in the *past*. Thus, each regulation places an independent condition on the availability of reimbursement under Medicare, and each must be satisfied before payment can be made. For example, if a provider claims a cost for a new educational service that has never previously been provided (and thus never been paid for by the community), reimbursement would be permitted under subsection (c). Cf. *St. John's Hickey Memorial Hosp., Inc.* v. *Califano*, 599 F.2d 803, 810 (7th Cir. 1979) (regulation does not bar reimbursement where affiliated college establishes new educational program). Under subsection (g), however, the amount of reimbursement to which the provider would be entitled would be calculated as the cost of the program minus the amount the provider received in tuition payments.

C. The Secretary's Construction Of 42 C.F.R. 413.85(c) Is Not Arbitrary Or Capricious Or Inconsistent With The Medicare Act

Petitioner and its amici also claim (Pet. Br. 36-37; AHA Br. 22-23, 25-27) that the Secretary's construction of the educational activities regulation should be rejected because it leads to "arbitrary" results that are incompatible with the text and purpose of the Medicare statute. They contend that denying reimbursement based on a provider's failure to claim costs in the past is inconsistent with the statutory definition of "reasonable costs." 42 U.S.C. 1395x(v)(1)(A). That Section, however, confers very broad authority on the Secretary to determine the "reasonable cost" of a medical service that would be entitled to reimbursement. That authority encompasses the discretion to determine the "items to be included" in the category of reimbursable services. 42 C.F.R. 1395x(v)(1) (1970). Thus,

the Secretary may decide what types of services are allowable—*i.e.*, are covered by Medicare at all—as well as the level at which those services are reimbursed.

Petitioner's argument rests on the false assumption that the existence of outside sources of funding for educational activities is irrelevant to the Secretary's determination of the "reasonableness" of Medicare's payment of the costs of those activities. There is nothing arbitrary about the Secretary's refusal to pay for educational programs that have been previously funded, on a voluntary basis, by other sources, whether public or private. Although the training received by interns and residents in hospital GME programs may redound to the benefit of patients in a number of ways, Medicare's basic purpose is to pay for direct medical services to patients, not to fund medical education. It would not have been inconsistent with the "reasonable cost" language in Section 1395x(v)(1)(A) for the Secretary to have elected to exclude GME program costs from Medicare reimbursement altogether. The Secretary instead adopted regulations that permit reimbursement of a portion of such costs. In determining the extent to which federal funds earmarked for patient care should be used to support educational programs that do arguably advance Medicare's objectives, the Secretary had the discretion to make Medicare the payor of last resort, and to limit Medicare's responsibility by placing principal funding responsibility elsewhere, *i.e.*, on the "community."

The Secretary's application of the anti-redistribution and community support principles is, as we have discussed, consistent with congressional intent as manifested in the committee reports on the Medicare Act, and in the statutory directive that the Secretary follow payment principles "generally applied by national organizations"—*e.g.*, the "community support" principle set forth in the American Hospital Association's *Principles of Payment*

for Hospital Care. See pages 19-20, *supra*. Moreover, the Secretary's practice is grounded in the legitimate commonsense judgment that Medicare funding for a provider's educational activities is an effective use of scarce Medicare dollars only under limited circumstances—that is, only until such time as the community has undertaken to bear those costs. If a provider did not previously claim the costs, for whatever reason, then it is not an unreasonable assumption (at least absent evidence to the contrary) that the provider was able to conduct the programs despite the absence of Medicare funding because alternative sources of funding were found to pay the costs of the programs. Once other funds have been made available to support educational programs, it is within the Secretary's discretion to decide that support from Medicare is not needed to ensure that the provider will continue to carry on its educational activities, and that the limited funds available to the Medicare program would best be applied elsewhere.[17]

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[17] Petitioner and its amici suggest that inclusion of "hospital fees" or patient care revenues in the category of prior "community support" that would bar Medicare reimbursement for certain services (see Pet. App. 18a, 32a) is inconsistent with the Medicare Act's "cross-subsidization" provision, which directs that the Secretary's regulations ensure that "the necessary costs of efficiently delivering covered services" to Medicare beneficiaries not be "borne by individuals not so covered." 42 U.S.C. 1395x(v)(1)(A). See Pet. Br. 32, 36-37; AHA Br. 23-24, 26-27. The question whether the funding of educational programs using patient care revenues constitutes a form of "community support" is not presented by this case, because the GME costs in dispute were previously borne by the Medical School, not the Hospital, and fees paid by non-Medicare patients to the Hospital therefore were not a prior source of funding for the costs.

In any event, it is fully consistent with the "cross-subsidization" provision of Section 1395x(v)(1)(A) to take account of support furnished out of hospital fees. The cross-subsidization principle is not violated unless the costs allegedly being "shifted" are allowable Medicare costs.

D. The Agency Has Been Consistent In Its Interpretation Of 42 C.F.R. 413.85(c)

The materials cited by petitioner and its amici lend no support to the argument that HHS has previously applied 42 C.F.R. 413.85(c) in a manner inconsistent with the Secretary's position in this case. Indeed, most of those materials do not even discuss the anti-redistribution principle. Petitioner seeks to infer from that silence the existence of a contrary policy. Needless to say, however, the Secretary does not establish policy by omission.

Petitioner and its amici first point (Pet. Br. 22; AHA Br. 17-18) to an internal operating guideline issued by the Health Care Financing Administration (HCFA) in HHS in February 1978 that reviewed a "number of situations" relating to reimbursement of costs incurred by medical schools affiliated with providers. Intermediary Letter No. 78-7 (Pet. App. 64a-66a). The Intermediary Letter was concerned primarily with detailing the categories and amounts of educational expenses incurred by affiliated medical schools that might be allowable to providers. It did not purport to be a comprehensive review of all conditions that might be placed on reimbursement of educational costs, and it did not address the issue of redistribution at all.

Petitioner similarly relies (Pet. Br. 22-23) on an exchange of memoranda within HCFA in 1982 regarding the

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See *North Clackamas Community Hosp.* v. *Harris*, 664 F.2d 701, 707 (9th Cir. 1980) (Kennedy, J.). Under 42 C.F.R. 413.85(c), costs that do not satisfy the anti-redistribution and community support principles are not allowable costs, and Medicare reimbursement therefore is not available to help defray them. Where medical education costs are found to be allowable, they will be apportioned between Medicare and non-Medicare patients in proportion to the medical services received from the provider, in the same manner as other costs. Neither category will impermissibly subsidize the other.

University of Oregon's health training programs. Once again, however, the absence of discussion of the anti-redistribution principle by the HCFA central headquarters official in his response to the Regional Administrator scarcely manifests a contrary HCFA policy. Indeed, a subsequent memorandum issued in 1985 by the Director of HCFA's Division of Hospital Payment Policy pointed out that the 1982 central office memorandum "did not specifically discuss the policy with respect to the redistribution of costs from a medical school to a hospital," and stated that "[t]he fact that [the redistribution issue] is not mentioned in the subject memorandum does not change the basic policy as espoused in 42 CFR [413.85(c)]." J.A. 27.[18]

Petitioner and its amici next argue (Pet. Br. 25; AHA Br. 18-19, 20) that an inference favorable to their position may be drawn from the Secretary's "failure * * * to articulate a policy of redistribution" in response to public

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[18] In light of the 1985 memorandum specifically confirming the continued vitality of the anti-redistribution principle, the Director's failure to expound upon that principle in a letter she wrote to the Oregon Health Sciences University three months later (see J.A. 29-30), relied upon by petitioner (Pet. Br. 23-24), is of little moment, and certainly does not signify an abandonment of the agency's position on the anti-redistribution clause. (In a portion of the letter omitted from the Joint Appendix, HHS explained the disallowance of some of the provider's claims based on other grounds. See Pet. C.A. App. 118-119.)

Petitioner also relies (Pet. Br. 24 n.12) on a 1993 PRRB decision in claiming that HCFA failed to apply the anti-redistribution principle against the Oregon University Hospital Program. That PRRB decision concerned the Oregon Program's attempt to claim Medicare reimbursement for costs incurred between 1978 and 1981. As petitioner concedes, the PRRB never reached the issue of whether those costs might be disallowed under the anti-redistribution language in Section 413.85(c); it disallowed the costs at issue based on the Medicare reopening regulations.

comments concerning proposed regulations implementing the 1985 COBRA amendments, Pub. L. No. 99-272, § 9202(a), 100 Stat. 171 (1986), which established a "base year" for reimbursing health education costs. See 54 Fed. Reg. 40,286 *et seq.* (1989); pages 5-6, *supra*. The regulations, among other things, required a reaudit of providers' previously submitted cost reports for GME expenses incurred during the base year. The passage in the preamble to the regulations to which petitioner refers consists of a response to an inquiry by a commenter on the proposed regulations as to whether a provider is forbidden under the anti-redistribution principle in 42 C.F.R. 413.85(c) from collecting Medicare reimbursement for GME costs incurred by an affiliated medical school when "State appropriations or other funding sources are sufficient to cover the costs of operating the medical school." 54 Fed. Reg. 40,302 (1989) (J.A. 43). That inquiry concerned the issue of "offset"—*i.e.*, the effect of the availability of outside funding during the cost reporting year in question. It was not directed at the effect of the payment of costs through the use of public or private sources in *past* years (which is the concern of the anti-redistribution regulation). See pages 27-29, *supra*. Thus, it is not surprising that the Secretary's reply focuses on reviewing the proper application of subsection (g) of the regulation with respect to grants, but does not specifically address the anti-redistribution principle in subsection (c). See 54 Fed. Reg. 40,302 (1989) (J.A. 44-45).

Likewise, it is of no significance (see AHA Br. 20) that the Secretary did not discuss the community support and anti-redistribution principles in response to a suggestion by a commenter on the same regulations that hospitals should be able to introduce additional GME costs "not previously claimed, as well as misclassified costs," during the reaudits of base-year period cost reports authorized by

the regulations. 54 Fed. Reg. 40,301 (1989) (J.A. 42). The Secretary's response addressed the limited question of whether 42 C.F.R. 413.85(c) allows a provider to revise a base-year period cost report to include GME costs incurred by a related medical school in the base year that were inadvertently omitted in an initial cost report for that same year. 54 Fed. Reg. 40,301 (1989) (J.A. 42-43). It did not address the distinct question of whether mistakenly omitted costs would be reimbursable if they had not been claimed in cost reports for previous years and had instead been absorbed by the provider or an affiliated medical school in those years.

Finally, petitioner and its amici suggest (Pet. Br. 21, 29-30; AHA Br. 19, 24) that Medicare's willingness to pay claims for the costs of providers' educational programs during the year when those costs were first claimed demonstrates that the Secretary's enforcement of the community support and anti-redistribution principles is of recent vintage. They argue in particular that, because the Hospital's preexisting program must have been supported by the "community" prior to the filing of its first claim for educational costs in 1974, application of the Secretary's interpretation of the regulation would have barred reimbursement of the claim.

Petitioner's argument has little force, because it is not possible to determine at this point the extent to which, and why, the costs claimed in 1974 were considered by the intermediary to be reimbursable under the Secretary's regulation. In the first place, if a provider (rather than its affiliated medical school) has previously incurred such costs but has not claimed them under Medicare, reimbursement of those provider costs by Medicare for the first time would not constitute a redistribution of costs from an educational institution to a patient care institution in violation of the anti-redistribution clause of 42 C.F.R. 413.85(c), and the presumption of prior community

support in that setting might be rebutted in other respects. See note 10, *supra*. Moreover, any unprecedented costs incurred by the provider or its affiliated medical school—for example, costs for new programs, or the costs of expanding preexisting programs—could have been reimbursed without violating the community support or anti-redistribution principles. See PRM § 404.2 (J.A. 57). In short, because the details of the Hospital's cost reports for its GME programs prior to 1974 are not part of the record of this case, it is impossible to tell whether the initial decision to support petitioner's GME programs was consistent with the Secretary's interpretation of the regulation at issue.

Contrary to petitioner's suggestion (Pet. Br. 26), the absence until recently of administrative and judicial decisions reflecting the Secretary's interpretation of 42 C.F.R. 413.85(c) does not show that the Secretary only recently adopted that interpretation, or that the Secretary previously took a contrary position. There is a more plausible explanation for the dearth of controversy surrounding application of the educational activities regulation prior to the mid-1980's. As a practical matter, intermediaries experienced a surge in claims for costs incurred in connection with providers' educational programs following the changeover from the "reasonable cost" to the prospective payment system (PPS) of reimbursement for non-education costs after 1983. The revision in the Medicare reimbursement method for non-educational services, combined with increased costs and a diminution of financial support for educational programs in general, furnished an impetus for providers to ferret out previously unclaimed costs that could be attributed to the provider's educational activities, which were still being reimbursed on a "reasonable cost" basis. See, *e.g.*, J.A. 8-13. As a result, intermediaries invoked 42 C.F.R. 413.85(c) to reject claims for GME costs previously absorbed by a pro-

vider's affiliated medical school or otherwise supported by the community, which in turn led to review of these decisions by the Secretary and the courts.[19]

In sum, and contrary to petitioner's assertion (Pet. Br. 26), the Secretary's position in this case does not represent a repudiation of any longstanding interpretation of the regulation at issue, and there is no evidence that the Secretary's position is "newly arrived at" for the purposes of this case. The Secretary has consistently adhered to the position advanced here in other litigation concerning the application of this regulation to graduate medical education costs, see, *e.g.*, *Board of Regents of the Univ. of Minnesota* v. *Shalala*, 837 F. Supp. 303 (D. Minn. 1993);

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[19] That trend was noted in the decision of the Administrator in *University of Minnesota Hospitals & Clinics* v. *Blue Cross & Blue Shield Ass'n*, reviewing PRRB Dec. No. 91-D29, in which the Administrator observed that

> [a]s a result of PPS and the corresponding provision for pass-through medical education costs, it became apparent that teaching hospitals were attempting to claim costs not previously the responsibility of the Provider or reimbursed by Medicare so as to increase reimbursement in response to the medical education pass-through provisions of PPS.

Slip op. 8 n.16 (citing Medicare Regional Intermediary Letter No. 87-9 (Feb. 6, 1987), which noted that "some teaching hospitals are improperly claiming institutional costs not previously reimbursed by Medicare * * * for the first time"); accord, Medicare Contractor Regional Bulletin No. 87-4 (Mar. 4, 1987). We have lodged copies of these materials with the Clerk of this Court. See also testimony of Touche Ross & Co. employee Gaynor (J.A. 14-16) (agreeing that hospitals have been re-evaluating their practices "with respect to claiming medical school costs" because of reductions in state and private support for medical schools and diminished provider revenues due to "reimbursement reform and competition").

Ohio State University v. *Secretary, United States Dep't of Health & Human Services*, 996 F.2d 122, 124 (6th Cir. 1993), petition for cert. pending, No. 93-696 (filed Nov. 1, 1993); *Board of Trustees* v. *Sullivan*, 763 F. Supp. 178, 184-185 (S.D. Miss. 1991), and petitioner points to no case in which the agency has taken a different position.

* * * * *

In this case, the Secretary found that the disputed costs of the provider's GME programs had, in past years, been paid by its affiliated Medical School out of public and private funds supplied by sources other than Medicare. The district court did not disturb that finding, see Pet. App. 18a-19a, and its decision was affirmed by the court of appeals.[20] Under the Secretary's interpretation of 42 C.F.R. 413.85(c), which is reasonable and entitled to deference by this Court, the disputed expenses had thus been "borne by the community," Pet. App. 15a-16a, and could not in any event be redistributed from the Medical

[20] Petitioner states at one point (Pet. Br. 9) that, during the period relevant to this case, the "Medical School operated at a deficit." It cites in support an isolated assertion by one of its employees in the administrative proceedings that "[w]ithout taking into account such things as gifts and grants, alumni giving endowments, [the Medical School] operated at a deficit" in 1985. Although the existence of a *past* deficit incurred by a provider or medical school, if it could be directly tied to the burden of supporting an educational program, might serve to rebut the presumption of community support, that principle does not help petitioner here. First, the assertion by the Hospital employee in this case relates to a deficit in the cost reporting year, not in past years. Second, the Hospital employee's remarks are not probative of community support because the sources of funding that the employee excluded from consideration in determining whether the Medical School was operating at a deficit would count as sources of community support. The employee's testimony thus fails to reveal whether the Medical School would have run a deficit if those sources of funding had been considered.

School to the Hospital for purposes of Medicare reimbursement. Both courts below sustained the Secretary's interpretation and application of her own regulation to that effect, and this Court therefore should affirm the judgment below.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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No. 93-120

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1993

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d/b/a Thomas Jefferson University Hospital,
Petitioner,

v.

DONNA E. SHALALA, SECRETARY
Department of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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INTRODUCTION

The Secretary's brief is a creative exercise in *post hoc* rationalization of her policy which does not hide the fact that her interpretation of the relevant regulation is contrary to the 20-year history of that regulation and is completely inconsistent with the Secretary's regulatory scheme. Indeed, a review of the regulation on its face, its place in the Secretary's regulatory scheme, the Medicare statute it is supposed to implement, and the Secretary's

previous policies and statements in this area readily reveal that the Secretary's interpretation of the regulation offered here is inconsistent with the Medicare statute, arbitrary, capricious and not supported by substantial evidence.

ARGUMENT

I. THE SECRETARY'S INTERPRETATION OF THE "COMMUNITY SUPPORT" LANGUAGE IN SECTION 413.85(c) IS INCONSISTENT WITH HER REGULATORY SCHEME AND WITH HER PREVIOUS INTERPRETATION OF THE GME REGULATIONS

The Secretary argues here that the "community support" language found in 42 C.F.R. § 413.85(c) is a separate and independent bar to reimbursement of costs incurred in connection with a hospital's GME programs. Respondent's Br. at 17-18. The problem with the Secretary's claim is that it (a) is completely incompatible with her own regulatory scheme; (b) is totally inconsistent with her 20-year history of treatment of GME cost claims; and (c) results in absurd reimbursement decisions that are directly contrary to express Congressional intent. The Secretary's attempt in her brief to account for these inconsistences is entirely unpersuasive.

A. The Secretary's Interpretation of the "Community Support" Language Makes No Sense In the Context of Her Regulatory Scheme

The Secretary's own regulatory scheme contradicts her claim that section 413.85(c) is a force, separate and independent from paragraph (g), for analyzing the total amount of a provider's reimbursement for GME costs in a given year. Paragraph (a) sets forth the general rule for

payment of GME costs. According to this provision, "a provider's allowable cost may include its net cost of approved educational activities, *as calculated under paragraph (g)*." 42 C.F.R. § 413.85(a) (1985) (J.A. 40) (emphasis added). Paragraph (a) makes no mention of deducting or accounting for "community support" under paragraph (c).

Paragraph (g), as it existed during the cost year at issue here, provided that net costs of approved activities are determined by deducting from a provider's total costs of those activities "revenues it receives from tuition." 42 C.F.R. § 413.85(g) (J.A. 41). Previously, the regulation had required that other forms of revenue -- those the Secretary now claims constitute "community support" (*i.e.*, grants, gifts and donations) -- should also be deducted from total costs to determine the net allowable GME costs. *See* 20 C.F.R. § 405.421(b)(2) (1966) (J.A. 34) and § 405.421(g)(1) (1980) (J.A. 39). The Secretary modified the regulation prior to the cost year at issue here to provide that those items need not be offset from total costs to determine net allowable GME costs. 49 Fed. Reg. 234, 296 (Jan. 3, 1984) (J.A. 39-40). The Secretary has concluded that the offset of such contributions "appears to dilute the effect of the contribution," and therefore, "may discourage private philanthropy." *See* 48 Fed. Reg. 39,752, 39,757 (Sept. 1, 1983) (reprinted in Appendix to Brief of *Amici Curiae* State of Ohio, *et al.*, at 15a-16a).[1]

Here, however, the Secretary advances the position that the very items which she eliminated from the offset provisions of paragraph (g) can nevertheless be used to reduce claims for GME reimbursement under paragraph (c). Respondent's Br. at 17-18. The Secretary repealed the offsets under paragraph (g) because she found they discouraged philanthropy. She does not explain why denying

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[1] *See also* Argument section I.C., *infra*.

reimbursement of current costs on the basis of past grants under paragraph (c) does not *also* discourage philanthropy. The Secretary's failure to articulate a coherent policy on community support means her position in this case is not entitled to deference.

B. The Secretary's Interpretation of the "Community Support" Language is Contrary to 20 Years of Prior Interpretations

In addition to lacking any support in common sense or logic, the Secretary's interpretation of "community support" as advanced here is contrary to her own previous statements and actions.

The Secretary's current interpretation of paragraph (c) is completely inconsistent with her prior rulemaking under paragraph (g). If, as the Secretary here asserts, paragraph (c) is a separate bar to recovery of GME costs where certain items -- gifts, grants and donations -- have in the past been received by the hospital, then it makes no sense ever to have included gifts, grants and donations as items to be deducted from total costs under paragraph (g). Yet for years those items were so included. Moreover, when she revised her regulations to eliminate the offset for gifts, grants and donations in paragraph (g), the Secretary failed to point out that these exact same items were still to be counted as "community support" and must still be analyzed when "satisfying" the regulation's "independent condition" under paragraph (c). Respondent's Br. at 28-29.[2]

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[2] This is not simply "establish[ing] policy by omission." Consider how the Secretary's past actions and current interpretation interact. In 1984, the Secretary eliminated the offset under paragraph (g) for grants, gifts and donations. The next year, every hospital with GME costs which previously had been deducting those items from total costs was (continued...)

As described in the Brief of *Amici Curiae* the American Hospital Association, *et al.*, the Secretary's own forms for submitting cost reports contain no reference to "community support," much less a line item or instruction regarding where and how a hospital is supposed to account for the "community support" the Secretary now claims is and always has been required by paragraph (c). *See* AHA Br. at 13-14 and n.6. Yet the forms *do* and always have contained instructions regarding the deduction of items required to be offset under paragraph (g). The Secretary did not even respond to this argument. Moreover, the Secretary's Provider Reimbursement Manual ("PRM"), a detailed policy manual, nowhere mentions "community support" in the context of GME. Certainly the PRM contains no instructions for how a fiscal intermediary is to determine that the "independent condition" set forth in paragraph (c) has been "satisfied."

In addition, the Secretary has publicly admitted that for the first 20 years of the Medicare program (a period that encompasses the year under review), Medicare imposed no deduction or ceiling based on "community support." In the Preamble to a 1985 rule which was to provide a one-year

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[2](...continued)
allowed, in effect, to increase its net allowable GME costs by the amount of those gifts, grants and donations. According to the Secretary, however, paragraph (c), which "is concerned with whether costs have historically been paid from sources other than Medicare in the *past*," places an "independent condition" on the availability of Medicare reimbursement to these hospitals, that "must be satisfied before payment can be made." Respondent's Brief at 28-29 (emphasis in original). Obviously, these hospitals have received funds *other than Medicare* in the past (*e.g.*, the gifts, grants and donations previously offset from total costs under (g)) from which costs have been paid. Thus, the "independent condition" of paragraph (c) cannot be satisfied, and the Secretary is justified in refusing to pay the increased GME costs. Although the Secretary denies that her interpretation gives with one hand and takes away with another (Respondent's Br. at 28), it obviously does.

moratorium on increases in reimbursement for medical education costs, the Secretary stated:

> we believe that *after 20 years of very generous support by the Medicare program, that it is time to implement the Congressional intent* that local communities assume a greater role in the costs of medical education.

50 Fed. Reg. 27,722, 27,723 (July 5, 1985) (emphasis added).[3] She also referred to "Medicare's policy of basing its reimbursement on 100 percent of the reasonable direct costs of approved educational activities," 50 Fed. Reg. 21,026 (May 21, 1985), and to the Medicare policy of providing "virtual open-ended funding" for medical education. 50 Fed. Reg. at 27,723.[4] Obviously, the Secretary was not then interpreting paragraph (c) to provide an "independent" basis for limiting GME payments.

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[3] The Secretary's proposal to establish a one-year moratorium on increases in medical education costs was codified at 42 C.F.R. § 405.421(a)(2) (1985). The moratorium was to apply to a hospital's first cost reporting year beginning or after July 1, 1985 -- which would have been Petitioner's first cost reporting year beginning after the year under appeal in this case. Congress enacted legislation which precluded the Secretary from implementing the moratorium. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9202(i), enacting 42 U.S.C. § 1395x(v)(1)(Q), *reprinted in* 1986 U.S.C.C.A.N. (100 Stat.) 82, 177. Instead, Congress enacted the per resident methodology in 42 U.S.C. § 1395ww(h). Pub. L. No. 99-272, § 9202(a), 1986 U.S.C.C.A.N. (100 Stat.) at 171.

[4] These statements demonstrate that the Secretary's claim here that Medicare is the "payor of last resort" for medical education costs, and her attempt to suggest that the program has always considered that medical education costs need only partially be paid is simply not true. Respondent's Br. at 30. The Secretary is engaged in *post hoc* rationalization of this policy, but the explanation is totally inconsistent with her public record on the issue.

Significantly, she believed that additional regulatory action was required to impose such a limit.

C. The Secretary's Interpretation of "Community Support" Results In Absurd Reimbursement Decisions, Clearly Contrary to Express Congressional Intent

The Secretary's analysis of section 413.85(c) presented here -- suggesting that gifts and grants can be used to reduce reimbursable costs -- is flatly inconsistent with the Medicare statute. In the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 901(a)(1), *reprinted in* 1980 U.S.C.C.A.N. (94 Stat.) 2599, 2611, enacting 42 U.S.C. § 1320b-4 (App. 1a), Congress codified the Secretary's then-existing practice that *unrestricted* gifts, grants and donations were not to be offset from the operating costs of non-profit hospitals when calculating reimbursable Medicare costs. Congress also gave the Secretary the authority to eliminate the deduction for "[t]hose types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity) . . . which the Secretary determines, in the best interests of needed health care, should be encouraged." App. 1a.[5] The Secretary's interpretation of section 413.85(c), which treats *all* grants, gifts and donations as "community support," the past existence of which can be used to deny GME reimbursement, is contrary to Congress' intent in passing the legislation.

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[5] Pursuant to this authority, the Secretary promulgated the amendments to 42 C.F.R. § 405.423 (eliminating the deduction for donor-restricted gifts, grants and endowment income from the calculation of "reasonable" Medicare costs), and 42 C.F.R. § 413.85(g) (eliminating the deduction for donor-restricted gifts, grants and endowment income from the calculation "net" GME costs). *See* Appendix to Brief of *Amici Curiae* State of Ohio, *et al.*, at 15a-16a.

> It is the intent of the conference committee that the prohibition against deducting gifts, grants, endowments, and income therefrom, shall apply *indirectly as well as directly* and preclude the Secretary from taking into account the presence of charitable funds generated from gifts, grants or endowments which have not been designated by the donor for paying any specific operating costs as a reason for denying *any reimbursable expense* . . . .

H.R. Conf. Rep. No. 1479, 96th Cong., 2d Sess. 140 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5903, 5931 (emphasis added) (App. 2a-3a). The Secretary cannot claim that where grants are given to a medical school and not a hospital, the statute is inapplicable. Offsetting the hospital's cost claim by grants received by its related medical school "indirectly" reduces the hospital's reimbursement.

Reading the regulation according to the Secretary's current interpretation simply makes no sense applied to a real reimbursement situation. According to the Secretary, "subsection (g) calculates 'net cost' as a function of the availability of outside funds *during the cost reporting period in question*. Subsection (c), in contrast, is concerned with whether costs have historically been paid from sources other than Medicare in the *past*. Thus, each regulation places an independent condition on the availability of reimbursement under Medicare, and each must be satisfied . . . ." Respondent's Br. at 28-29. But how does this work as applied in the real world?

Assume Hospital A is a licensed operator of GME programs and a division of a university that also operates a medical school. Hospital A's GME programs are staffed by physicians who are actually employed by (that is, paid by) the medical school. Both the hospital and the medical school are divisions of a single entity -- the university. In Year 1,

Hospital A's medical school receives a grant from a private donor of $1,000. Section 413.85(g), the Secretary acknowledges, provides that the $1,000 grant need not be deducted from Hospital A's total costs, and thus, has no effect on Hospital A's allowable Medicare GME program reimbursement during the year in question.

In Year 2, the $1,000 grant is continued. As in Year 1, the $1,000 grant received in Year 2 is not required to be offset from Hospital A's total costs in Year 2 to determine total allowable costs. 42 C.F.R. § 413.85(g). But how is the "independent condition" provided by paragraph (c) to be satisfied? Is the Hospital required to deduct the $1,000 grant received in Year 1 from Year 2 total costs -- to reflect that in the past $1,000 in revenues were received from sources other than Medicare? This doesn't seem quite right -- why is the $1,000 deductible in Year 2 when it was not in Year 1? Why should the $1,000 received in Year 1 be deducted from Year 2 costs when the $1,000 actually received in Year 2 need not be?

The Secretary does not address any of these hard questions. Nor does she explain why requiring an offset in the year the grant is actually received violates Congressional policy by discouraging private donations, but using the existence of past grants to deny current reimbursement does not. Instead she blithely asserts generalizations, "each regulation places an independent condition on the availability of reimbursement . . . ." (Respondent's Br. at 29) without offering a single explanation for how this generalization is to be implemented in the context of her regulatory scheme. As noted *supra* at 5, the Secretary has never issued any regulations or interpretations explaining *how* this "independent condition" is actually to be implemented. The obvious conclusion is that paragraph (c) is not an "independent condition" at all, but rather, as Petitioner asserts, serves to provide the rationale for the more specific provisions in the medical education regulation.

D. The Secretary's Attempts to Dismiss Her Inconsistent Interpretations Of "Community Support" Are Unconvincing

The Secretary's attempts to explain away her inconsistent interpretations of "community support" are unpersuasive. First, she claims that her previous treatment of the Petitioner cannot be *proved* to be inconsistent because the record does not demonstrate *why* the costs claimed for the first time in 1974 were considered to be reimbursable. Respondent's Br. at 35. The Secretary speculates that the Hospital's claim might fall within one of the distinctions she identifies in her brief (although these distinctions cannot be found anywhere in the Secretary's regulations or policy guidelines) such as that the Hospital had experienced "unprecedented" costs or costs for "new" programs. Respondent's Br. at 36. She suggests that her position might not be inconsistent at all if the pre-1974 costs had been paid by the provider, rather than the medical school, and if the presumption of community support were somehow overcome. *Id.*

The Secretary's musings and speculation are contradicted by the record and by the Administrator of HCFA, whose decision is the decision of the Secretary. The Administrator concluded that "[p]rior to 1974, the Provider's educational program was *solely* supported by the community, *i.e.*, tuition, hospital fees, grants, bequests, and state funded support from Pennsylvania and Delaware." Pet. App. 32a (emphasis added). These are the *exact* same sources of funding the Secretary argues had previously supported the medical school and justified denying Petitioner's 1985 claim. Moreover, the fiscal intermediary (the Secretary's agent for calculating the amount of reimbursement owed in the first instance) also claimed at the Provider Reimbursement Review Board ("PRRB") that the Hospital's 1974 claim for GME reimbursement was a "redistribution" of costs from the

"community" and the medical school to Medicare. A.R. 41, 59.

The Secretary's argument is disingenuous at best. First she argues that it is perfectly appropriate for her to presume that if a hospital has been operating GME programs without Medicare payments in the past, those programs must have been supported by the community and can (and indeed are required by the community support language in paragraph (c)) continue to get by without Medicare payments. Respondent's Br. at 30-31. When confronted with the evidence that *this* hospital had in fact been operating GME programs from the beginning of the Medicare program until 1974 with no Medicare support, but then requested and received for the first time Medicare payment for GME costs beginning in 1974, the Secretary denies that this is an inconsistent application of her policy because the record does not reveal why payment was made. The record does reveal, however, that prior to 1974, the program *solely* was supported by the community, under the Secretary's current interpretation of that term. Thus, there is no question that the Secretary's treatment of the Hospital's 1985 request for reimbursement of GME costs is a departure from her past practices.[6]

Second, the Secretary's attempt to avoid the most irrational aspects of application of her new interpretation by

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[6] The Secretary's claim that there was no need to adopt this interpretation prior to 1985 because there was a "surge" in claims for increased Medicare reimbursement is undermined by this same record evidence. Obviously, hospitals had made claims for increased GME reimbursement, indeed, they had made *first time* claims for GME reimbursement prior to the mid-1980s. Petitioner made a first time claim in 1974. The Oregon University Health Science Center made a first time claim in 1982-83. Petitioner's Br. at 22-24. And many hospitals were making claims for related-party medical school GME reimbursement in the mid-1970s because that is obviously what triggered the agency to issue Intermediary Letter 78-7 instructing intermediaries how to treat such claims.

claiming that certain GME costs not previously claimed might nevertheless be reimbursed is totally unsupported. According to the Secretary's brief, "if a provider claims a cost for a new educational service that has never previously been provided (and thus never been paid for by the community), reimbursement would be permitted under subsection (c)." Respondent's Br. at 29. This argument suggests that no program in existence prior to 1966 could qualify for Medicare reimbursement, yet that obviously is not what happened.

Finally, the Secretary fails adequately to address her own public pronouncements of policy which are inconsistent with her current claim that paragraph (c) provides "independent conditions" which must be separately satisfied to determine a provider's ultimate reimbursement. For example, in the preamble to the 1989 GME regulation, the Secretary was specifically asked to address "whether there is a *redistribution* of GME costs when *State appropriations or other funding sources* are sufficient to cover the costs of operating the medical school." 54 Fed. Reg. 40,286, 40,302 (Sept. 29, 1989) (J.A. 43) (emphasis added). The Secretary's response to this question deals *only* with the provisions of paragraph (g) regarding deductions from total costs. It does not mention the "independent condition" provided by paragraph (c) that allegedly restricts the amount of GME reimbursement available when grants, gifts and other funding sources are available to support GME program costs. The Secretary justifies this blatant inconsistency by misstating the question. According to the Secretary, her answer's focus on paragraph (g) was appropriate because the "inquiry concerned the issue of 'offset'. . . ." Respondent's Br. at 34. The inquiry quite obviously did not concern "offset." It concerned redistribution in the context of a related party medical school which was supported by non-Medicare funds. According to the Secretary's position here, such funds are presumptive "community support." Her failure to address the "independent condition" of

paragraph (c) which she claims must be satisfied separately prior to determining a hospital's allowable GME reimbursement is powerful evidence that in 1989 at least she did not think that the community support language was implicated by the commenter's question.

II. THE SECRETARY'S CURRENT INTERPRETATION OF THE REDISTRIBUTION CLAUSE IS CONTRARY TO THE PLAIN MEANING OF THE REGULATION

The Secretary asserts that her interpretation of the redistribution clause of paragraph (c) should be upheld for many of the same reasons offered in support of her interpretation of the community support clause. Indeed, she basically merges the two concepts by asserting that she considers "financial support by an affiliated medical school for any aspect of the provider's educational programs as a form of 'community support'" (Respondent's Br. at 19), and thus, when a related-party medical school has previously borne costs of GME programs, not only is the redistribution principle violated, but so is the community support principle.[7]

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[7] The Secretary makes the remarkable claim that when the regulation is viewed from the perspective suggested here -- that a related-party medical school can properly be considered part of the "community," such that costs incurred by the related party are "community support" -- the Congressional purpose of increasing community support for GME programs is advanced. *See* Respondent's Br. at 19 n.11. This is absurd. When the Medicare statute was written, including the legislative history noting that communities were not supporting medical education programs, many teaching hospitals were affiliated with universities that also operate related-party medical schools. That is the same situation that exists today. Congress looked out at this landscape and said communities are *not* supporting graduate medical education. Until they do, Medicare must participate appropriately (that

(continued...)

There is no basis in the statute, the regulation or the Secretary's past practices for this interpretation. First, her interpretation completely ignores the related-party principle of her own regulation.[8] Pursuant to 42 C.F.R. § 413.17(a), the "costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization." In addition, the Secretary has specifically recognized, as acknowledged in Intermediary Letter 78-7, that allowable hospital costs include the reasonable costs

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[7](...continued)
is, along with other purchasers of hospital services) in the payment of these costs. Twenty years later, the Secretary has gazed out over the same landscape and discovered that if she re-labels the participants she can "increase" community support. There is absolutely no evidence that Congress intended for the Secretary to come along and examine how costs were historically paid, re-label payment by related-party medical schools as "community" support, and thereby declare victory in the effort to increase community support for GME programs.

[8] The Secretary's claim that Petitioner has abandoned its objection to the Administrator's holding that general administrative expenses of the medical school are not reimbursable is incorrect. Respondent's Br. at 9-10 n.7. In its Petition for a Writ of Certiorari, Petitioner specifically noted that the Secretary's regulations actually provide that full *direct and indirect* costs are to be taken into account in calculating the "net cost" under section 413.85(g). *See* Petition for Writ of Certiorari at 4-5. As discussed in the briefs of Petitioner and *amici*, it is the Secretary who has abandoned this argument as an alternative basis for denial of Thomas Jefferson's claim, and of Ohio State University's claim. *See* Petitioner's Br. at 14 n.9. *See also* Brief of *Amici Curiae* American Hospital Assoc., *et al.*, at 7 n.5; Brief of *Amici Curiae* State of Ohio, *et al.*, at 8-9 n.5. Although the Secretary revised her statement of the Question Presented in her brief to eliminate the reference to Petitioner's costs as "otherwise reimbursable," she does not dispute Petitioner's contention that she has abandoned this issue.

incurred by a related medical school in support of a hospital's GME programs. *See* Pet. App. 64a.

The point of the related-party regulation is to recognize the reality of transactions between such entities, *i.e.*, that they are not arm's length transactions, but rather transfers between entities which are essentially alter egos. 42 C.F.R. § 413.17(c)(2). Since related organizations, such as a medical school and a hospital which are divisions of a university, are merely alter egos of each other, to claim that payment of costs by one of the entities is the equivalent of community support is absurd. The provisions of section 413.17(a) are very specific. Those specific provisions provide that the costs of a related organization *are* allowable hospital costs.[9] Moreover, the Secretary's specific instructions to intermediaries provides that where a medical school which is related to a hospital by common ownership provides services to the hospital's GME programs, the medical school's costs are allowable hospital GME costs. It is inappropriate to construe the general "redistribution" language in paragraph (c) to conflict with these specific provisions, particularly when such a construction is inconsistent with the plain wording of paragraph (c) itself.[10]

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[9] Significantly, nothing in the wording of section 413.17 suggests any exception for medical education costs. Moreover, specific recognition of the applicability of the related-organization principle to medical education costs is found in 42 C.F.R. § 405.481(a) (App. 3a). That provision defines "physician compensation" costs reimbursable by Medicare to encompass costs incurred by a provider or "entities related to the provider" under 42 C.F.R. § 413.17. *Id.*

[10] The Secretary erroneously accuses Petitioner of ignoring the redistribution language in paragraph (c). Petitioner has not ignored that language (the second phrase in the last sentence of paragraph (c)) but, like the *Ohio State* courts, has construed that language in light of the first phrase in the sentence, *i.e.*, "the intent of the program is to share in the support of educational activities customarily or traditionally carried on by
(continued...)

The Secretary also dismisses the array of evidence indicating she has never previously interpreted the redistribution provision in the manner she asserts here by claiming that she does not "establish policy by omission." Respondent's Br. at 32.[11] The record reveals that the Secretary has done much more than "establish policy by omission." She has in fact affirmatively asserted that the redistribution principle *does not* bar reimbursement of the clinical teaching costs incurred by a related-party medical school in support of a hospital's GME programs.

For example, in PRM § 404.2 (J.A. 56-58), the Secretary discusses redistribution in the context of nursing and paramedical training programs. The Secretary specifically distinguishes between clinical training programs -- the costs of which are always allowable -- and classroom training -- the costs of which are allowable only if the program is operated by the provider. According to the Secretary, the portion of section 404.2 which states, "[i]f the non-provider reduces its costs due to receiving provider support, such reduction constitutes a redistribution," is a "general rule" which is not "confined to the redistribution of classroom costs." Respondent's Br. at 24-26 n.14. A simple glance at section 404.2 reveals that this is a serious distortion.

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[10](...continued)
providers in conjunction with their operations." 42 C.F.R. § 413.85(c). *See Ohio State University v. Sullivan*, 777 F. Supp. 582, 586-87 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122, 124 (6th Cir. 1993). As the Secretary's brief reflects, the Secretary has failed to give any effect at all to that critical language.

[11] As noted *supra* at 12-13, the Secretary's attempt to explain her failure to articulate the policy on "redistribution" she espouses here, in response to a public comment asking specifically for an explanation of "redistribution" in the context of a state-supported university operated GME program, is not persuasive.

Section 404.2 is divided into several sections. The quoted passage comes from a section labelled "Non-Provider-Operated Programs Supported By Providers." There, the Secretary instructs that costs incurred "which are related to the *classroom* portion [of a non-provider operated program] are allowable if . . . three criteria are met." The first criterion, under the discussion of allowability of *classroom* costs, is: "The provider's support does not constitute a redistribution of non-provider costs to the provider." J.A. 57.

As a further explanation of that criterion, the PRM offers the passage quoted by the Secretary. The Secretary's claim that this passage is a general limitation on reimbursement of medical education costs -- clinical or classroom -- is preposterous. On the contrary, what the manual says about clinical costs is: "Costs incurred for the clinical training at the provider are allowable." J.A. 56. *No* conditions or criteria are imposed on the allowability of those costs, and redistribution is not mentioned.

III. THE SECRETARY'S CLAIM THAT THE MEDICARE STATUTE GIVES HER UNFETTERED DISCRETION TO ESTABLISH ANY MEDICARE REIMBURSEMENT POLICY SHE WANTS IS WRONG

The Secretary's suggestion that she possesses essentially unbridled authority under the Medicare statute is plainly contradicted not only by the plain wording of the statute but by the case law. The two most significant statutory limits on the Secretary's authority which are relevant here are the requirements set forth in 42 U.S.C. § 1395x(v)(1)(A) that mandate reimbursement of actual costs necessary for the efficient delivery of needed health services and prohibit the shifting of Medicare costs to non-Medicare patients, and the requirement of 42 U.S.C. § 1320b-4 that for purposes of determining reasonable costs the Secretary

"shall not" deduct from operating costs unrestricted grants, gifts or endowments. Contrary to the Secretary's claim (Respondent's Br. at 22 n.12), courts of appeals do not "uniformly" uphold her regulations out of deference to the complicated nature of Medicare reimbursement. *See St. James Hosp. v. Heckler*, 760 F.2d 1460, 1470 (7th Cir.), *cert. denied*, 474 U.S. 902 (1985) ("a lesser degree of deference is required when reviewing the Secretary's actions under the Medicare Act's reimbursement provisions.").[12]

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[12] Indeed, Petitioner was able to identify easily nearly 30 cases striking down various of the Secretary's regulations on the grounds that they were contrary to the Medicare statute. A partial list of those cases includes: *St. Mary of Nazareth Hospital Center v. Heckler*, 760 F.2d 1311, 1315-19 (D.C. Cir. 1985) (Secretary's regulation relating to the practice of including labor/delivery patients as inpatients for purposes of calculating routine-cost Medicare reimbursement held invalid); *Humana, Inc. v. Heckler*, 758 F.2d 696, 703-07 (D.C. Cir. 1985), *cert. denied*, 474 U.S. 1055 (1986) (Secretary's regulation not permitting a revaluation of assets and an increase in equity capital in a stock acquisition when an acquired corporation is liquidated or merged into the acquiring corporation held invalid); *accord PIA-Asheville, Inc. v. Bowen*, 850 F.2d 739, 741 (D.C. Cir. 1988); *Bedford County Memorial Hospital v. HHS*, 769 F.2d 1017, 1023 (4th Cir. 1985) (Secretary's regulation which changed process by which hospitals are compensated for portion of their malpractice costs attributable to Medicare patients held invalid); *Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1381, 1386-88 (5th Cir.), *cert. denied*, 454 U.S. 940 (1981) (Secretary's disallowance of expenses incurred in the provision of free medical care to indigents under the Hill-Burton program held invalid); *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1212 (6th Cir. 1989) (Secretary's policy regarding reimbursement of costs for payment of stipends and related overhead of time spent by residents working in outpatient clinics held invalid); *accord Loyola University of Chicago v. Bowen*, 905 F.2d 1061, 1072 (7th Cir. 1990); *St. John's Hickey Memorial Hospital, Inc. v. Califano*, 599 F.2d 803, 812-15 (7th Cir. 1979) (Secretary's policy regarding reimbursement for portion of costs incurred by a nursing education program held invalid); *Vista Hill Foundation, Inc. v. Heckler*, 767 F.2d 556, 561-66 (9th Cir. 1985) (Secretary's policy denying reimbursement for (continued...)

Moreover, numerous other courts have rejected Secretarial policies as inconsistent with the regulations or arbitrary or capricious.[13] Deference is not appropriate here because, as demonstrated in Petitioner's brief, and as the court found in *Ohio State University v. Sullivan*, 777 F. Supp. at 587, the Secretary's policy here violates the Medicare Act.

CONCLUSION

For the reasons set forth here and in its opening Brief, Petitioner respectfully prays that the Court reverse the judgment of the Court of Appeals for the Third Circuit, and direct the Secretary to reimburse the Hospital for the

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[12](...continued)
educational costs provided to children as a part of a therapy modality in a psychiatric hospital held invalid); *Mercy Community Hospital v. Heckler*, 781 F.2d 1552, 1556-58 (11th Cir. 1986) (Secretary's policy regarding recapture of depreciation payments made to Medicare provider in connection with a sale of assets held invalid); *Sacred Heart Hospital v. United States*, 616 F.2d 477, 483-84 (Ct. Cl. 1980) (Secretary's policy regarding reimbursement of costs for administration of medical provider's inhalation therapy department held invalid).

[13] *See, e.g., Humana of Aurora, Inc. v. Heckler*, 753 F.2d 1579 (10th Cir.), *cert. denied*, 474 U.S. 863 (1985); *Lloyd Noland Hospital & Clinic v. Heckler*, 762 F.2d 1561 (11th Cir. 1985); *DeSoto General Hospital v. Heckler*, 766 F.2d 182 (5th Cir. 1985); *Annie M. Warner Hospital v. Harris, 639 F.2d 961 (3d Cir. 1981)*; *AMI-Chanco, Inc. v. United States*, 576 F.2d 320 (Ct. Cl. 1978); *Biloxi Regional Medical Center v. Bowen*, 835 F.2d 345 (D.C. Cir. 1987); *Charlotte Memorial Hospital & Medical Center, Inc. v. Bowen*, 860 F.2d 595 (4th Cir. 1988); *Community Hospital of Indianapolis, Inc. v. Schweiker*, 717 F.2d 372 (7th Cir. 1983); *Columbus Community Hospital, Inc. v. Califano*, 614 F.2d 181 (8th Cir. 1980); *Guernsey Memorial Hospital v. Sullivan*, 996 F.2d 830 (6th Cir. 1993); *Faulkner Hospital Corp. v. Schweiker*, 702 F.2d 22 (1st Cir. 1983); *Memorial, Inc. v. Harris*, 655 F.2d 905 (9th Cir. 1980).

reasonable costs incurred in support of its GME programs, in accordance with the findings of the PRRB.

Respectfully submitted,

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Dated: April 11, 1994

APPENDIX

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Omnibus Reconcilation Act of 1980,
P.L. No. 96-499 *enacting*
42 U.S.C. § 1320b-4

For purposes of determining, under titles V, XVIII, and XIX of this Act, the reasonable costs of services provided by nonprofit hospitals, the following items shall not be deducted from the operating costs of such hospitals:

(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

(2) A grant or similar payment which is to such a hospital, which was made by a governmental entity, and which is not available under the terms of the grant or payment for use as operating funds.

(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

(4) The proceeds from the sale or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

* * * *

House Conference Report No. 1479
Omnibus Reconciliation Act of 1980

Nonprofit Hospital Philanthropy

House Bill. -- The House bill provides that grants, gifts, and income from endowments, whether restricted by the donor or not (as well as certain income from philanthropic gifts, and other funds) shall not be deducted from operating costs of nonprofit hospitals in determining reimbursement under the medicare, medicaid and Maternal and Child Health programs.

Senate amendment. -- No provision.

Conference agreement. -- The conference agreement modifies the House provision to specify that the following items shall not be deducted from the operating costs of nonprofit hospitals in determining reimbursement amounts: (1) grants, gifts or endowments, and the income therefrom, which have not been designated by the donor for paying any specific operating costs; (2) governmental grants or similar payments, under the terms of which the grant or payment is not available for use as operating funds; and (3) the proceeds from the sale or mortgage of any real estate or other capital asset which the hospital acquired through gift or grant and which, under the terms of the gift or grant, are not available for use as operating funds (except for recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.)

In determining reimbursement amounts, the Secretary would continue to have authority not to deduct from operating costs certain types of donor-designated gifts and grants (including government grants) if he or she determines that it would be in the best interest of needed health care not to make a deduction with respect to such types of grants or gifts. It is intended the exemption currently contained in regulations relating to family practice training grants would be continued.

It is the intent of the conference committee that the prohibition against deducting gifts, grants, endowments, and income therefrom, shall apply indirectly as well as directly and

preclude the Secretary from taking into account the presence of charitable funds generated from gifts, grants or endowments which have not been designated by the donor for paying any specific operating costs as a reason for denying any reimbursable expense, such as interest expense.

42 C.F.R. § 405.481(a)

(a) Definition. For purposes of this subpart, physician compensation costs means monetary payments, fringe benefits, deferred compensation and any other items of value (excluding office space or billing and collection services), a provider or other organization furnishes a physician in return for the physician's services. Other organizations are entities related to the provider within the meaning of § 413.17 of this chapter, or entities that furnish services for the provider "under arrangements" within the meaning of the Act.

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1993

No. 93-120

THOMAS JEFFERSON UNIVERSITY, d/b/a
THOMAS JEFFERSON UNIVERSITY HOSPITAL,
Petitioner,

v.

DONNA E. SHALALA, Secretary,
Department of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES AS AMICI CURIAE IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether an administrative decision disallowing Medicare reimbursement to petitioner hospital for "otherwise reimbursable" categories of graduate medical education costs incurred on its behalf by a related medical school solely because petitioner did not claim Medicare reimbursement for those costs in prior years conflicts with the Medicare statute and regulations or is arbitrary and capricious.

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IN THE SUPREME COURT OF THE UNITED STATES

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BRIEF FOR AMERICAN HOSPITAL ASSOCIATION AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES AS AMICI CURIAE IN SUPPORT OF PETITIONER

At issue is the validity of a 1990 administrative decision construing a 1966 regulation governing Medicare reimbursement for education costs. The agency's 1990 construction of the regulation is contrary to more than 20 years of consistent agency practice in the area of graduate medical education ("GME"). The agency's 1990 determination is invalid because (1) it is inconsistent with the plain wording and intent of the Medicare education regulation; (2) it contravenes the governing Medicare statute; and (3) it is arbitrary and capricious.

INTEREST OF AMICI CURIAE

The American Hospital Association ("AHA") is the primary national membership organization for hospitals in this country, consisting of approximately 5,400 hospitals and other health care institutions. The AHA's goal is to promote high-quality health care and health services for all through leadership and assistance to hospitals in meeting the health care needs of their communities. Many of the AHA's members are teaching hospitals.

The Association of American Medical Colleges ("AAMC") was founded more than a century ago to improve the process and quality of medical education. Its members include all accredited medical schools in both the United States and Canada; nearly 400 major teaching hospitals; more than 90 academic and professional societies representing some 72,000 members of medical facilities; and students and medical residents at these schools and hospitals. Strengthening the quality of GME is a matter of special concern to the AAMC and its many members.

The amici have a significant interest in this case because the challenged agency decision adversely affects the financial well-being of some of their teaching hospital members, thereby impairing the hospitals' ability to furnish high-quality GME. Of equal importance, however, is the amici's concern with the lack of fundamental fairness represented by the agency decision.

The regulation in question has never been controversial in the GME area in the past; the agency always construed the regulation consistently with its precatory phraseology. Suddenly, in 1990, the agency adopted a radical new construction, one which, had it been applied in 1967 (when the Medicare program began operations), would have precluded virtually any teaching hospital from ever receiving any Medicare reimbursement for GME, in clear contravention of Congressional intent. Moreover, the agency

did so without even expressly acknowledging the radical departure from prior policy, much less providing a rational explanation for the departure. The agency's current interpretation establishes absurd disparities among teaching hospitals based solely on the sophistication (or lack thereof) of the reimbursement claims filed in prior years. These disparities cannot be reconciled with the plain wording of the Medicare statute and regulations or with fundamental principles of fairness.

Principles of administrative law require, at a minimum, that an agency changing its course furnish advance notice, a rational explanation of what its new policy is, and a reasonable explanation for the change. The agency decision in this case fails on all scores. The decision below sets a very unfortunate precedent with ramifications for the amici's members (as well as for regulated parties in general) beyond the specific question addressed.

In recognition of the AAMC's and the AHA's interest in this case, both parties have consented to the filing of this brief.

STATEMENT

The petitioner's brief contains a full statement of the case. The amici rely on that statement. They recite here only facts which, in their view, are particularly worth noting.

I. GENERAL BACKGROUND

1. The Medicare statute was enacted in 1965 to furnish health insurance benefits for persons aged 65 or over. Pub. L. No. 89-97, § 102(a). Medicare providers were

reimbursed on the basis of their "reasonable cost." [1] 42 U.S.C. § 1395x(v)(1)(A).

2. The Secretary of what was then the Department of Health, Education, and Welfare and is now the Department of Health and Human Services ("the Secretary") issued implementing regulations in 1966. 31 Fed. Reg. 14,808. Then, as in 1985 (the cost year at issue), the Secretary's regulations provided for payment of Medicare's share of "the net cost of approved educational activities." 20 C.F.R. § 405.421(a) (1967). [2] "Net cost" was defined as "the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations." 20 C.F.R. § 405.421(b)(2) (1967). The Secretary's regulations also contained the same paragraph (c) (addressing, among other things, community support and the redistribution of educational costs) whose construction is at issue in this case. 20 C.F.R. § 405.421(c) (1967).

3. Since their original promulgation, the only significant changes to the education regulation relevant to this case have been to the definition of "net cost." In 1980, certain grants and donations were exempted from offset. 45 Fed. Reg. 51,783, 51,786-51,787. In 1984, the offset of grants and gifts was eliminated in its entirety. 49 Fed. Reg. 234, 296, 313. As a result, the only offset remaining in the regulations

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[1] In 1972, the statute was amended to provide for reimbursement of the lower of "reasonable costs" or "customary charges." See 42 U.S.C. § 1395f(b)(1). Only in unusual circumstances are a provider's customary charges less than its reasonable costs.

[2] The education regulation was originally codified at 20 C.F.R. § 405.421. In 1977, it was recodified as 42 C.F.R. § 405.421. 42 Fed. Reg. 52,826. In 1986, it was recodified as 42 C.F.R. § 413.85. 51 Fed. Reg. 34,790.

is for tuition. See 42 C.F.R. § 405.421(g) (1984); 42 C.F.R. § 413.85(g) (1993).

4. In 1983, Congress adopted a prospective payment system ("PPS") to reimburse most hospitals for most inpatient operating costs, but retained cost reimbursement principles for certain costs, including medical education costs. Pub. L. No. 98-21, § 601(e); 42 U.S.C. § 1395ww(a)(4). In April 1986, Congress adopted a new payment methodology for GME costs for cost reporting years beginning on or after July 1, 1985. Pub. L. No. 99-272, § 9202. That system is not relevant to this case, which involves a cost reporting year subject to payment for GME costs under "reasonable cost" principles.

II. FACTS SPECIFIC TO CASE

1. Petitioner has been a Medicare provider of hospital services since the beginning of the program. It has trained interns and residents in GME programs for many years, but it did not begin to claim Medicare reimbursement for GME costs incurred by its related medical school for its GME program until 1974. From 1974 through 1983, petitioner claimed (and received) Medicare reimbursement for resident stipends and for the compensation and fringe benefits paid by the related medical school to faculty members for training petitioner's residents.

2. In 1984, petitioner expanded its Medicare GME claims to include the clerical and office space costs incurred by the related medical school for petitioner's GME program. The Medicare fiscal intermediary reimbursed petitioner's 1984 claims in full.

3. For its 1985 fiscal year (July 1, 1984-June 30, 1985), petitioner hired a national accounting firm to identify with particularity all of its allowable GME costs, including GME costs incurred on its behalf by the related medical school. The study demonstrated that, for many years, petitioner had

been underclaiming the amount of GME costs allowable under Medicare. For its 1985 fiscal year, petitioner sought reimbursement for GME costs in accordance with the results of the study. [3] The Medicare intermediary disallowed the increased costs claimed by petitioner, contending that reimbursement of those costs would violate paragraph (c) of the Medicare education regulation.

4. On November 17, 1989, the Provider Reimbursement Review Board ("PRRB or "Board") reversed the intermediary's disallowances. The Board concluded that reimbursement of petitioner's claims was consistent with paragraph (c) because:

> the Provider is merely claiming additional support costs for the GME programs it has historically operated utilizing the services of the related Medical School's faculty. The refinement of costs associated with these educational activities does not constitute a redistribution of costs from the educational unit to the patient care unit.

Petition Appendix ("Pet. App.") at 59a.

5. On January 18, 1990, the Administrator of the Health Care Financing Administration ("HCFA"), the agency within the Department of Health and Human Services responsible for administration of the Medicare program, modified the Board's decision. The Administrator stated:

> [T]hat the Provider did not claim these costs in an earlier cost year is evidence of the communities [sic] support for these activities. To allow the community

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[3] Petitioner's 1985 fiscal year was its last year subject to payment for GME under "reasonable cost" principles. From its 1986 fiscal year through the present, petitioner has been subject to payment for GME under the 1986 legislation establishing the GME per resident amount methodology.

> to withdraw that support and pass these costs to the Medicare program would result in a redistribution of costs in violation of 42 CFR 413.85(c).

Pet. App. at 35a. He held that petitioner "may only be paid for those medical education costs which it has traditionally claimed and been allowed prior to 1984." [4] Id. at 37a.

6. The HCFA Administrator did not rely entirely on paragraph (c) of the education regulation. He also held, in the alternative, that the additional categories of medical school education costs identified in the study "would not be allowable medical education costs under any circumstance." Id. at 36a. The Secretary abandoned this argument before the court of appeals. [5] In her brief filed in response to the petition for certiorari, the Secretary has conceded that, but for paragraph (c), the disputed costs are "otherwise reimbursable GME program costs." See Question Presented; see also Brief at 8.

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[4] The parties subsequently stipulated that petitioner was entitled to the increased GME costs identified in the 1985 study, including those incurred by the medical school, related to the categories of GME costs for which petitioner had received Medicare reimbursement prior to 1984. Pet. App. at 11a-12a n.5.

[5] The district court did not address the Administrator's holding on this point. However, in Ohio State University v. Sullivan, 777 F. Supp. 582, 588-590 (S.D. Ohio 1991), aff'd, 996 F.2d 122 (6th Cir. 1993), the court demonstrated the inconsistency of the Administrator's holding with Medicare principles. Following the Ohio State district court decision, the Secretary abandoned the HCFA Administrator's alternative holding in both the Ohio State litigation and the instant case. See Secretary's Petition for a Writ of Certiorari, Shalala v. Ohio State University, No. 93-696 at 6 n.5.

SUMMARY OF ARGUMENT

I. The Administrator's construction of paragraph (c) conflicts with its plain wording. Paragraph (c) is phrased in general, precatory, and explanatory language. It is properly read as providing the rationale for the specific provisions of the regulation. The Administrator has impermissibly converted the general language in paragraph (c) into independent prohibitions that conflict with the specific provisions. Moreover, his construction is contrary to binding agency policy issuances, as well as more than 20 years of prior agency practice. Consistent with its plain wording, the decisions in the Ohio State litigation, and the agency's prior practice, paragraph (c) applies only to a redistribution of educational costs which, unlike the costs of training interns and residents, are not "customarily or traditionally carried on by providers in conjunction with their operations," but rather are carried on by educational institutions.

II. The Administrator's construction conflicts with the Medicare statute. The statute expressly requires Medicare to bear its proportionate share of necessary costs. It does not exempt Medicare from this obligation if a provider waived its lawful entitlement in prior years.

The legislative history relied on by the Administrator clearly refutes his position. If the Administrator's construction of "community support" were correct, the ability of hospitals to operate GME programs prior to the enactment of Medicare would have precluded their ever receiving Medicare reimbursement. However, the legislative history shows that Congress believed communities were not supporting GME in 1965 and it was therefore necessary for Medicare to bear its share of these costs. There is no evidence that Congress ever reversed that judgment.

III. The Administrator's decision is arbitrary and capricious. It establishes irrational distinctions among similarly-situated hospitals based solely on the sophistication

of their prior Medicare claims. It makes no more sense for the Secretary to deny a provider's lawful current Medicare entitlement based upon a waiver in prior years than for the IRS to deny a tax deduction because a taxpayer failed to claim the deduction in prior years. Moreover, denying lawful claims because of waivers in prior years is just as absurd as reimbursing unallowable costs because of erroneous payments in prior years. Mistakes should be corrected, not perpetuated.

The Administrator's decision is simplistic and superficial. He eschewed all the "hard questions" raised by the case. He thereby failed to meet his obligation to provide a reasoned explanation for what was a dramatic change in course. Moreover, because the Administrator departed from his own legislative rules, he was required to act through rulemaking, not adjudication.

ARGUMENT

I. THE ADMINISTRATOR'S 1990 CONSTRUCTION CONFLICTS WITH THE PLAIN WORDING AND LONG-STANDING IMPLEMENTATION OF THE MEDICARE EDUCATION REGULATION.

A. Inconsistency of Administrator's Construction With Plain Wording of Regulation

The Administrator and the district court focused exclusively on paragraph (c) of the education regulation. Pet. App. at 14a, 33a. That was a mistake because, to be properly understood, paragraph (c) must be read in context.

As of 1983, the education regulation read in relevant part as follows:

> (a) A provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section.

(b) *Definition--Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

....

(g) *Calculating net cost.* (1) Except as specified in paragraph (g)(2) of this section, net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities,

revenues it receives from tuition, and from grants and donations that the donor has designated for the activities. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

(2) Effective for cost reporting periods beginning on or after January 1, 1978, grants and donations that the donor has designated for internship and residency programs in family medicine, general internal medicine, or general pediatrics are not deducted in calculating net costs.

42 C.F.R. § 405.421 (1983).

Prior to petitioner's 1985 fiscal year, Paragraph (g) was amended to read as follows:

Calculating net cost. Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

42 C.F.R. § 405.421(g) (1984). Otherwise, the regulation remained unchanged.

In his 1990 decision, the Administrator construed paragraph (c) as precluding a hospital from receiving reimbursement for particular categories of education costs if it did not receive reimbursement for those categories in prior years. He stated that the absence of prior Medicare funding demonstrates "community support" and defined "community support" broadly to include "tuition, hospital fees, grants, [and] bequests." Pet. App. at 32a. The Administrator's

construction does not comport with the plain wording of paragraph (c), when read in context with the regulation as a whole, or with the Secretary's traditional understanding of that paragraph.

The governing rule is stated in paragraph (a): A Medicare provider is entitled to reimbursement of "its net cost of approved educational activities." Paragraph (g) defines with specificity the required deductions. Paragraph (b) defines "approved educational activities." Where requirements are imposed, mandatory language is employed. For instance, paragraph (b) states that the activities "must be licensed where required by State law" and, where not so required, "must receive" alternative specified approval. (Emphasis added.)

The wording of paragraph (c) contrasts sharply with the specificity and mandatory phraseology of other provisions in the regulation. It is phrased almost entirely in descriptive or precatory language. It includes only one flat declaratory statement: "[I]t is necessary that support be provided [for approved educational activities] by those purchasing health care." The language in paragraph (c) is naturally read as explaining the rationale for the specific provisions in the regulation.

The Administrator did not adopt the natural reading. Instead, in his 1990 decision, he converted the general, explanatory language in paragraph (c) into all-encompassing, independent prohibitions which are fundamentally at odds with the liberalization of the definition of "net cost" that occurred during the 1980s. Originally, the regulation required the offset of "any reimbursements from grants, tuition, and specific donations." 31 Fed. Reg. 14,808, 14,814 (1966); 20 C.F.R. § 405.421(b)(2) (1967). In 1980, the regulation was amended (effective for cost reporting years beginning on or after January 1, 1978) to preclude the offset of "grants and donations that the donor has designated for internship and residency programs in family medicine,

general internal medicine, or general pediatrics." 45 Fed. Reg. 51,783, 51,786-51,787 (1980); 42 C.F.R. § 405.421(g) (1980). On January 3, 1984, it was further amended to preclude the offset of any grants or donations. 49 Fed. Reg. 234, 296, 313 (1984). The regulation in effect during petitioner's 1985 fiscal year required only the offset of "revenues . . . from tuition." 42 C.F.R. § 405.421(g) (1984).

The Administrator's decision renders paragraph (g) meaningless. His construction of paragraph (c) requires the offset of all the revenues specifically exempted by the amendment of paragraph (g) during the early 1980s. Moreover, his suggestion that "hospital fees" (i.e., patient care revenues) should be considered "community support" conflicts not only with paragraph (g) but also with the statement in paragraph (c) that, because of the absence of community support, "it is necessary that support be provided by those purchasing health care," thus obviously excluding "patient care revenues" from "community support." In one fell swoop, the Administrator has attempted, through adjudication, to reverse what his regulations clearly prescribe.

Paragraph (g) governs Medicare offsets for Medicare education costs. Any construction of the general language in paragraph (c) must be consistent with paragraph (g). The Administrator's construction fails because it conflicts with the clear mandate of that paragraph.

Significantly, the Secretary's extensive cost reporting forms and instructions during the cost reporting years at issue also contradict the Administrator's 1990 construction of the regulations.[6] The 1983 cost reporting form and

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[6] Medicare providers report their annual claims in a lengthy document known as a Medicare cost report. See 42 C.F.R. §§ 413.20(b), 413.24(f) (1992). The Secretary has issued very

(continued...)

accompanying instructions specifically require the offset of grants and donations and nursing school tuition, as mandated by the Secretary's definition of "net cost" prior to the 1984 amendment to the Medicare education regulation. See 1983 Instructions, ¶ 1216; see also Form HCFA-2552-83, Worksheet A-8, line 27. The 1984 cost reporting form only requires an offset of nursing school tuition, consistent with the amended definition of "net cost." See Form HCFA-2552-84, Worksheet A-8, reprinted in Medicare & Medicaid Guide (CCH), Report No. 457, 2d Extra Ed., Part II (Apr. 30, 1985). Nothing in the Secretary's 1983 or 1984 cost reporting forms or instructions suggests the necessity of further deductions based on paragraph (c) of the Medicare education regulation.

B. Correct Construction of Paragraph (c)

The very general, precatory language in paragraph (c) does not establish prohibitions which would alter the principle in paragraph (a) that a provider is entitled to reimbursement of "its net cost of approved educational activities" or the specific provisions in paragraph (g) defining the costs included and the revenues offset in calculating net cost. In-

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[6](...continued)
detailed instructions for the completion of cost reporting worksheets. See, e.g., Provider Reimbursement Manual ("PRM"), Part II, Ch. 15 - Provider Cost Reporting Forms and Instructions, Form HCFA-2552-84, reprinted in Medicare & Medicaid Guide (CCH), Report No. 457, 2d Extra Ed., Part I (April 30, 1985) (instructions for the cost reporting form prescribed for cost reporting periods beginning after September 30, 1983 and before October 1, 1984) [hereinafter "1984 Instructions"]; PRM, Part II, Ch. 12 - Provider Cost Reporting Forms and Instructions, Form HCFA-2552-83 (instructions for the cost reporting form prescribed for cost reporting periods beginning after September 30, 1982 and before October 1, 1983) [hereinafter "1983 Instructions"].

stead, paragraph (c) is properly read as providing the rationale for reimbursing education costs and the philosophical underpinning for the specific provisions in the regulation. For instance, to the extent that the words in paragraph (c) regarding community support have current relevance, [7] they explain why certain revenues should be deducted from gross education costs to calculate the "net cost" reimbursable under Medicare. Paragraph (g), in turn, specifies exactly which revenues must be offset.

The reference to "redistribution of costs" in the final sentence of paragraph (c) must be understood in light of the fact that educational activities under Medicare include not only the training of interns and residents, but also the training of nurses, medical students, and paramedical specialists. [8] The training of residents is entirely clinical; the residents have already successfully completed years of classroom training for which they have received an M.D. degree. Pet. App. at 16a-17a. In contrast, the education of nurses, medical students, and paramedical specialists involves partly clinical training and partly classroom instruction. Traditionally, classroom instruction for those students has often taken place in educational institutions. It is understandable that Medicare would not wish to begin reimbursing providers for the classroom instruction traditionally provided in educational institutions, not providers.

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[7] The references track language from a 1965 Senate report discussed in § II.B below. They may simply reflect the Secretary's and Congress' hope in 1965 (a hope as yet unfulfilled) that local communities would eventually undertake responsibility for medical education.

[8] Paramedical specialists include, among others, inhalation therapists, physical therapists, occupational therapists, and X-ray technicians. 42 C.F.R. § 413.85(e).

It is a mistake to read the words regarding "redistribution" in isolation. They are part of a sentence that begins: "the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations." Those words limit the scope of the "redistribution" language which follows. Accordingly, when read in context, the sentence as a whole precludes only a redistribution of costs for educational activities which, unlike the training of interns and residents, are not "customarily or traditionally carried on by providers in conjunction with their operations," but rather are carried on by educational institutions. That was the unanimous conclusion of the PRRB. Pet. App. at 59a. That was also the conclusion of the district court and the Sixth Circuit in the Ohio State litigation involving this issue. 777 F. Supp. at 585-587; 996 F.2d at 124.

The distinction drawn by the Ohio State courts between clinical training and classroom instruction in non-provider settings finds specific support in section 404.2 of the Provider Reimbursement Manual ("PRM"), an interpretative guide issued by the Secretary. Joint Appendix ("J.A.") at 56-58. That section (addressing specifically the costs of approved nursing and paramedical education programs) provides that the costs incurred in provider-operated programs "including costs of classroom training and costs of clinical training are allowable." PRM § 404.2A; J.A. at 56. For non-provider-operated programs supported by providers, it notes that the "clinical training portion generally is conducted in a provider or other health care setting" and states that the "[c]osts incurred for the clinical training at the provider are allowable." PRM § 404.2B; J.A. at 56. However, with respect to the costs "which are related to the classroom portion" in such non-provider-operated programs, the Manual provides for reimbursement only if, among other things, there is not "a redistribution of non-provider costs to the provider." PRM § 404.2B.1; J.A. at 57. Thus, the Administrator's application of paragraph (c) to the costs of

clinical training is inconsistent with the Secretary's own interpretative guide. [9]

Further support for the Ohio State interpretation of paragraph (c) is found in Intermediary Letter No. 78-7, a policy guide issued by the Secretary in February 1978 addressing reimbursement to teaching hospitals of costs incurred on their behalf by related medical schools. The letter states that such costs are allowable provided that they "would be allowable if incurred directly by the hospital rather than under such arrangement." Pet. App. at 64a. The letter provides detailed instructions and worksheets for identifying and documenting the related costs. Id. at 64a-66a. [10] Nowhere does it suggest that the redistribution language in paragraph (c) might be a barrier to a teaching hospital claiming education costs incurred on its behalf by the related medical school. [11]

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[9] In his decision, the HCFA Administrator relied on PRM § 406, which provides that "[t]he traditional practice followed in the past with respect to types of services rendered and the costs related thereto between providers and educational institutions shall be followed." Pet. App. at 33a. That provision is of no assistance to the agency in this case. The "traditional practice" (as recognized in PRM § 404.2) is that clinical training is the responsibility of providers, not educational institutions; the education of residents consists entirely of clinical training and is conducted entirely in patient care settings.

[10] The worksheets have been omitted from the Petition Appendix, but may be found at [1978 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 28,895.

[11] Paragraph (c) was part of the original Medicare education regulations published in 1966, and thus preceded the issuance of Intermediary Letter 78-7 by nearly twelve years.

Had the construction adopted in the Administrator's 1990 decision represented the Secretary's view in 1978, the contents of Intermediary Letter 78-7 would have been dramatically different. Any instructions to the intermediary on the subject of related medical school costs would have begun with the admonition that a hospital could not claim the education costs incurred by a related medical school unless it had done so in prior years. Moreover, even teaching hospitals which had done so in prior years would have been barred from identifying new categories of GME costs not previously claimed. Such language is conspicuously absent from Intermediary Letter 78-7.

Finally, additional support for the Ohio State holding is found in the preamble to the 1989 GME reaudit regulations. [12] The Secretary addressed therein whether a hospital's claims for GME costs incurred on its behalf by a related medical school might constitute a "redistribution of GME costs." 54 Fed. Reg. 40,302 (1989). The Secretary concluded that "services that are both related to the care and treatment of the hospital's patients and furnished in support of the training of interns and residents meet the requirements for payment." Id. She also concluded that the liberalization of the Medicare definition of "net cost" would preclude the offset of any grants or donations. Id. Nothing in the

[12] On September 29, 1989, the Secretary issued final regulations to implement the new payment methodology for GME costs. 54 Fed. Reg. 40,286. Under that methodology, hospitals are paid for future years based on their GME "reasonable costs" per intern and resident for a base year, updated for inflation. 42 U.S.C. § 1395ww(h). The Secretary's regulations required a reaudit of GME costs incurred during the base year. The accompanying preamble stated that "no new reimbursement principles will be applied during the reaudit" and described the agency's intent as "to ensure that the reimbursement principles in effect during the GME base period were correctly applied." 54 Fed. Reg. 40,301 (1989).

Secretary's rather detailed statement suggests that paragraph (c) establishes any independent barrier to reimbursement, even though the Secretary was expressly addressing whether claiming medical school costs as GME costs would constitute "a redistribution of GME costs." Id.

C. Inconsistency with Agency Interpretations and Practice

The Administrator's 1990 construction marks a radical departure from more than 20 years of consistent agency practice. That is evident from PRM § 404.2, Intermediary Letter No. 78-7, the liberalization of the definition of "net cost" that occurred during the early 1980s, the Secretary's cost reporting forms and instructions, and the preamble to the 1989 regulations governing reaudits of GME base years--all discussed in the preceding subsections. Further evidence is furnished by correspondence in the administrative record addressed in petitioner's brief.

Prior to the enactment of the Medicare program, hospitals obviously operated their GME programs without Medicare funds. Under the HCFA Administrator's 1990 construction, that fact should have precluded hospitals from receiving Medicare reimbursement for any GME programs in existence prior to Medicare. That is not, however, what happened. From the beginning of Medicare, hospitals with GME programs routinely sought reimbursement for Medicare's share of the net cost of the programs, and Medicare routinely paid the hospitals' claims.

The history of Medicare reimbursement for petitioner's GME costs is also noteworthy. In his decision, the Administrator noted that petitioner had operated its GME program for many years before claiming, for the first time in 1974, Medicare reimbursement for GME costs incurred by its related medical school. Pet. App. at 32a. Under the Administrator's current interpretation, since petitioner had not received Medicare reimbursement for those costs in prior

years, it would have been precluded from receiving Medicare reimbursement not only for 1974 but forever. That, of course, is not what happened. Consistent with the plain meaning of the education regulation, Medicare immediately began reimbursing petitioner's claims in 1974 and has continued to do so.

The change that occurred in petitioner's GME reimbursement claims in 1974 was far more dramatic than that which occurred in 1985. In 1974, petitioner began claiming GME costs never claimed before. In 1985, petitioner simply refined the methodology for establishing the amount of those costs. The 1974 claims were not considered a violation of paragraph (c) in 1974. That the Administrator's 1990 decision found the far more modest 1985 change to be a violation illustrates how radically the agency's current construction departs from traditional Medicare practice.

Likewise, the commentary published by the Secretary in the preamble to the 1989 regulations governing reaudits of the GME base year contradicts the Administrator's 1990 decision. The Secretary addressed therein whether, on reaudit, "hospitals should be able to introduce additional GME costs not previously claimed . . . to augment base-period GME costs." 54 Fed. Reg. 40,301 (1989). The Secretary responded that such costs could be allowed if the provider was able to provide documentation from the GME base year supporting the legitimacy of the costs. Id. Under the Administrator's 1990 construction, of course, that would not be the correct answer. If the GME costs "were not previously claimed," paragraph (c) would, under the Administrator's view, preclude Medicare reimbursement from ever being claimed for those costs. That was not, however, the Secretary's answer in September 1989 -- less than four months before the Administrator's decision in this case.

D. Necessity of Rulemaking

This is not a case in which the Administrator has sought to reverse through adjudication a policy adopted through adjudication. Here, the Administrator has sought to retroactively reverse through adjudication policies established by the Secretary's regulations and published interpretative guides.

An agency is, of course, bound by its own rules. United States v. Nixon, 418 U.S. 683, 694-96 (1974). If it wishes to reverse those rules, it must proceed by notice and comment rulemaking, not adjudication. American Federation of Government Employees v. Federal Labor Relations Authority, 777 F.2d 751, 758-760 (D.C. Cir. 1985). Moreover, any such reversal may apply only on a prospective basis. [13] Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988). Accordingly, even if the policy adopted in the Administrator's decision were consistent with the Medicare statute (addressed in § II below) and the Administrator had furnished a reasoned explanation for changing course (addressed in § III below), the Administrator's decision would nonetheless be invalid because the Administrator has attempted to apply his new policy without employing the mandatory notice and comment procedures of the Administrative Procedure Act.

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[13] In 1992, the agency issued a proposed rule designed to adopt the Administrator's new construction. See 57 Fed. 43,659, 43,672 (proposed 42 C.F.R. § 413.85(c)(2)). The rule has not yet been finalized.

II. THE ADMINISTRATOR'S 1990 CONSTRUCTION VIOLATES THE MEDICARE STATUTE.

A. Statutory Language

The Administrator's 1990 construction results in great disparities among similarly-situated hospitals. Suppose, for instance, that in Year X, Teaching Hospitals A, B, and C all had related medical schools which incurred $1 million in costs in connection with the administration of the Hospitals' GME programs. For prior years, Hospital A had accurately identified and claimed all medical school costs related to GME; Hospital B had identified and claimed only 50% of the medical school costs; and Hospital C had claimed none of the medical school costs. Under the Administrator's view, past practice would be binding. Hospital A's allowable costs in Year X would be $1 million; Hospital B's, only $500,000; and Hospital C's, nothing. Thus, even though Hospital C's Medicare patients received the same benefit from the training of interns and residents in Year X as Hospital A's, Hospital C would have to suffer in Year X and for all other years because in prior years it had waived its Medicare entitlement. The Administrator's construction creates enormous competitive disadvantages among hospitals that are providing the same degree of benefit to the Medicare patients they serve. It also perpetuates forever windfalls that the government has received because of hospital waivers in prior years.

There is no basis in the Medicare statute for the creation of such irrational disparities. The Medicare statute defines "reasonable costs" as "the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v)(1)(A). That Hospital C failed to claim Medicare reimbursement for a particular cost in prior years does not render the cost "unnecessary in the efficient delivery of needed health services." If the cost is necessary

in Hospital A's "efficient delivery of needed health services," logically it must also be "necessary" in Hospital C's — whether or not Hospital C waived its Medicare claim in prior years.

The cardinal principle of Medicare "reasonable cost" reimbursement is that Medicare must pay its fair share of health care costs. Specifically, the statute requires the Secretary's reimbursement principles to take into account both direct and indirect costs so that "the necessary costs of efficiently delivering covered services to [Medicare patients] will not be borne by [non-Medicare patients], and the costs with respect to [non-Medicare patients] will not be borne by [Medicare]." 42 U.S.C. § 1395x(v)(1)(A)(i). This provision is often known as the proscription against cross-subsidization.

There is no question that the costs in dispute in this case are "necessary." The Secretary has conceded that, but for petitioner's failure to claim them in the past, the disallowed costs are "otherwise reimbursable GME program costs." See Secretary's Petition Brief, "Question Presented." In the case of Hospital A (in the hypothetical above), the costs will be reimbursed. But the proscription against cross-subsidization would not allow a distinction between Hospitals A and C. The statute does not permit the Secretary to shift Medicare costs to non-Medicare patients if a hospital voluntarily permitted such a shift in past years by failing to claim Medicare's share. Rather, it places an affirmative duty on the Secretary to ensure that Medicare pays its fair share of "the necessary costs of efficiently delivering covered services."

Numerous courts have struck down the Secretary's administrative decisions relating to education costs based on the proscription against cross-subsidization. See, e.g., Ohio State University v. Sullivan, 777 F. Supp. at 587; Loyola University of Chicago v. Bowen, 905 F.2d 1061, 1073 (7th Cir. 1990); University of Cincinnati v. Bowen, 875 F.2d

1207, 1212 (6th Cir. 1989). The Administrator's 1990 decision is equally violative of this proscription.

B. Legislative History

In his decision, the HCFA Administrator relied on a passage from the Senate Report accompanying enactment of the Medicare statute. Pet. App. at 33a. The passage states:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.

S. Rep. No. 404, 89th Cong., 1st Sess. 36, reprinted in [1965] U.S.C.C.A.N. 1977 (1965).

That passage, far from supporting the Administrator's decision, refutes it. The Administrator essentially held that the absence of Medicare funding in past years demonstrates "community support" which precludes Medicare funding for current or future years. Under that logic, hospitals entering the Medicare program in 1967 would not have been entitled to Medicare reimbursement for educational costs because their ability to operate the programs in the past without Medicare funding evidenced "community support."

But that was clearly not the congressional committee's view of "community support." The cited passage reflects the committee's belief that in 1965 communities were not providing the necessary support, and it was therefore

necessary for Medicare to bear its fair share. It is obvious, therefore, that the committee, unlike the Administrator, did not equate the absence of Medicare funding in the past with "community support." Moreover, there has been no general undertaking by communities in the past 29 years to support hospital educational activities which would render unnecessary the Medicare support which Congress stated was necessary when Medicare was enacted. Thus, the Administrator's decision is inconsistent not only with the plain wording of the Medicare statute (which he ignored), but even with the legislative history upon which he relied.

III. THE ADMINISTRATOR'S 1990 DECISION IS ARBITRARY AND CAPRICIOUS.

Under the arbitrary and capricious standard, an agency must consider all relevant factors and "articulate a satisfactory explanation for its action including a "rational connection between the facts found and the choice made.'" Motor Vehicle Manufacturers Association of the United States, Inc. v. State Farm Mutual Automobile Insurance Co., 463 U.S. 29, 43 (1983), quoting, Burlington Truck Lines, Inc. v. United States, 371 U.S. 156, 168 (1962). Moreover, "an agency changing its course . . . is obligated to supply a reasoned analysis for the change. . . ." Motor Vehicle, 463 U.S. at 42.

The result reached by the HCFA Administrator is inherently implausible. Denying what the Secretary has conceded were "otherwise reimbursable GME program costs" because petitioner waived its entitlement to reimbursement for those costs in prior years is not only inconsistent with the Medicare statute, but it makes no sense. The IRS obviously could not deny a deduction for interest on a home mortgage because a taxpayer failed to claim the deduction in prior years. Nor could a welfare agency deny welfare benefits to an otherwise qualified applicant because he could have qualified, but failed to apply, for welfare in

prior years. The distinction drawn by the Administrator is equally ludicrous.

The logical ramifications of the Administrator's position should also be considered. If past practice is the criterion, it logically follows that a hospital which has mistakenly received GME reimbursement for unallowable costs in the past should continue to be reimbursed for those costs. The Secretary would undoubtedly object to making such payments, and she would, of course, be right. But it makes no more sense to deny allowable costs because a hospital waived its lawful entitlement in prior years than to reimburse unallowable costs because a hospital was mistakenly reimbursed in prior years. Mistakes should be corrected, not perpetuated.

Since the Administrator did not even admit that he was changing agency policy, he obviously could not provide a reasoned explanation for the change. [14] And, in fact, the Administrator's decision is remarkably simplistic, superficial, and conclusory. As the following demonstrates, the Administrator avoided all the "hard questions" relevant to a rational consideration of the propriety of changing a policy in effect for the prior 23-year history of the Medicare program.

1. The threshold question, of course, should be whether the change is consistent with the Medicare statute. As discussed in § II above, the Medicare statute bars the Secretary from shifting Medicare costs to other payors. Just a few months before issuance of the Administrator decision

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[14] An agency may not change its legislative rules through adjudication. American Federation of Government Employees, 777 F.2d at 758-760. Thus, even if the Administrator had furnished a reasoned explanation for the change, his action would nonetheless have been contrary to law because he did not utilize rulemaking procedures. See § I.D. above.

in this case, another Administrator decision involving education costs was reversed for violating this cardinal principle of Medicare reimbursement. See University of Cincinnati v. Bowen, 875 F.2d at 1212. Yet the Administrator failed even to consider the consistency of his new construction with the Medicare statute.

2. As discussed above, the Administrator's construction creates great disparities among similarly-situated hospitals. Yet the Secretary failed even to consider whether it is rational to create such disparities or equitable to penalize hospitals for prior waivers of reimbursement.

3. The Administrator failed to explain why the 1985 refinement of petitioner's GME claims constituted a violation of paragraph (c) when the filing of the original claims in 1974 did not.

4. The Administrator cited paragraph (c) of the education regulation as though the language ipso facto supported his result. But the Administrator never actually analyzed the language of the regulation. He did not consider, for instance, the relevance of paragraphs (a), (b), and (g). He did not note that paragraph (c), unlike other paragraphs in the regulation, is phrased in general, explanatory, and precatory language. He did not address why such language should suddenly be construed as independent "prohibitions" when it had not been so viewed in the past. He chose to ignore the liberalization of the definition of "net cost" that had occurred during the early 1980s. He made no attempt to reconcile his view of the general language in paragraph (c) with the specific language in paragraph (g) regarding offsets. He simply quoted paragraph (c) and declared magisterially that the paragraph obviously meant what, in fact, the Secretary had never before read it to mean.

5. Similarly, the Administrator simply cited the passage from the 1965 Senate report discussed in § II.B above, as though it were obvious that the language supported his

position. In fact, it is not at all obvious. The Administrator did not attempt to reconcile his broad view of "community support" with the Senate committee's belief that communities were not supporting hospital educational activities in 1965 and that it was therefore necessary for Medicare to bear its fair share. He also did not address whether there is any evidence that Congress had reversed its 1965 judgments regarding the inadequacy of community support and the necessity of Medicare funding. He also did not attempt to identify any growth in "community support" that had occurred since 1965 that would justify a departure from the Secretary's traditional position or Congress' mandate.

6. The Administrator did not address whether his new construction was consistent with the agency's published interpretations. He ignored, among other things, Intermediary Letter 78-7, PRM § 404.2, the Medicare cost reporting worksheets and instructions, relevant correspondence in the administrative record, and statements from the preamble to the 1989 GME per resident amount regulations applicable to this issue -- all discussed in § I above. He thereby avoided the hard task of explaining why he was not bound by the agency's prior interpretations, as reflected in those documents.

7. The Administrator did not address whether there was any change in circumstances which would justify a departure from the agency's prior policy. The only factor cited as a change was, in fact, not a change at all. The Administrator intimated that "the implementation of PPS and the corresponding provision for pass-through medical education costs" provided incentives for hospitals to claim costs not previously claimed. Pet. App. at 34a. That is clearly not true. PPS changed the reimbursement methodology for inpatient operating costs. It had no effect on reimbursement for medical education costs. See 42 U.S.C. § 1395ww(a)(4). For the year at issue, those costs continued to be reimbursed on a "reasonable cost" basis, as they had

since 1965. Accordingly, the incentive to identify GME costs accurately was created not by the enactment of PPS in 1983, but by the enactment of the Medicare statute in 1965.

Hospital efforts to identify GME costs more accurately were not new. Indeed, the reason that the Secretary issued Intermediary Letter 78-7 in February 1978 was to furnish hospitals and intermediaries with guidance regarding the identification of GME costs incurred by related medical schools. Moreover, there was nothing wrong with a provider asking Medicare to bear its fair share of all allowable costs; that is, after all, specifically what the Medicare statute commanded the Secretary to do. 42 U.S.C. § 1395x(v)(1)(A)(i).

8. The Administrator failed to accurately assess the evidence in the case. For instance, his statement that the Board's decision would allow "all costs for pre-existing activities . . . [to] be shifted, carte blanche, to the provider from the teaching institution" is absurd. Pet. App. at 34a-35a. The provider was claiming only medical school costs incurred in support of its GME program, which was only a small percentage of total medical school costs. Moreover, Medicare does not reimburse all allowable costs; it reimburses only its share based on the proportion of Medicare patients to total patients.

The foregoing analysis demonstrates that the Administrator ignored many relevant factors and failed to provide any explanation (much less a rational one) for departing from the agency's established policy. Accordingly, the Administrator's decision is clearly arbitrary and capricious.

CONCLUSION

For the foregoing reasons and the reasons stated in Petitioner's Brief, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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February 24, 1994

No. 93-120

In The

Supreme Court of the United States

October Term, 1993

THOMAS JEFFERSON UNIVERSITY, d/b/a
THOMAS JEFFERSON UNIVERSITY HOSPITAL,

Petitioner,

v.

DONNA E. SHALALA, SECRETARY
OF HEALTH AND HUMAN SERVICES,

Respondent.

On Writ Of Certiorairi
To The United States Court Of Appeals
For The Third Circuit

BRIEF OF AMICI CURIAE STATES OF OHIO, ARKANSAS, DELAWARE, LOUISIANA, MINNESOTA, NEW HAMPSHIRE, NEW YORK, PENNSYLVANIA, UTAH AND VIRGINIA IN SUPPORT OF PETITIONER

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ISSUE PRESENTED

Whether 42 C.F.R. § 413.85 allows providers to receive reimbursement for a fair share of all direct and indirect costs related to educational activities customarily or traditionally carried on by providers in conjunction with their operations.

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INTEREST OF AMICI CURIAE

The States that have joined this brief as amici curiae have a substantial interest in the outcome of this litigation. Each operates a Medicare-approved graduate medical education program ("GME program") for interns and residents in affiliation with an existing college of medicine. Each is entitled to receive reimbursement from Medicare for costs related to the GME program.

The Third Circuit Court of Appeals has affirmed a lower court decision holding that hospitals which conduct GME programs in conjunction with an existing college of medicine are precluded from recovering Medicare reimbursement for any indirect costs incurred by such programs if they have failed to seek reimbursement of these costs prior to 1985. In contrast, teaching hospitals which conduct their GME programs with their own staff and facilities are routinely permitted to recover these indirect costs. The Third Circuit's decision cannot be squared with existing law. If allowed to stand, the ruling will sanction discrimination against university hospitals and significantly impair the ability of such hospitals to provide interns and residents with the clinical experience necessary to meet the public's need for qualified physicians.

University hospitals have traditionally operated their GME programs through the use of the faculty, facilities, and other resources of existing educational units. It would be inefficient to require these hospitals to build new facilities and create new staffs when those resources are already in place. The operation of GME programs in

this common fashion is the most sensible and economical use of existing resources.

The effect of the Third Circuit's decision, however, is to penalize a select number of teaching hospitals – the majority of which are State institutions – as an extrastatutory means of streamlining the Medicare budget. But a regime that would preclude these hospitals from receiving Medicare reimbursement simply because they work in coordination with existing educational units would irrationally penalize the teaching hospitals for attempting to operate in the most efficient manner.

If health care reform is to become a reality, then the private and public health care sectors must continue to work together in close coordination to provide the medical education necessary to ensure the existence of a sufficient number of qualified practitioners. Quite simply, there is no authority for the Secretary to single out university-affiliated teaching hospitals, the majority of which are affiliated with State universities, and refuse to reimburse them for allowable costs related to their GME programs, simply as a unilateral method of reducing the Medicare budget. This unauthorized approach, moreover, is unfairly punitive, economically unsound, and directly undermines the ability of the States to continue to train individuals to become qualified health care practitioners.

SUMMARY OF ARGUMENT

The Third Circuit's judgment affirming the district court essentially holds that reimbursement of otherwise allowable indirect costs of a hospital's GME program will

be denied if those costs have not been claimed in the past. The Third Circuit's rationale is that it is always reasonable to assume that these costs were borne by the community simply because the hospital had not claimed reimbursement for them in the previous years. This decision is contrary to the plain language of the statute and regulations at issue and their legislative history as well as other relevant Medicare regulations.

42 C.F.R. § 413.85(c) recognizes the importance of Medicare's participation in training programs for health care professionals by providing reimbursement for the direct and indirect costs of a hospital's educational activities in such programs. 42 C.F.R. § 413.85(g) provides a specific formula for calculating the allowable costs of such programs. That formula includes all direct and indirect costs of the education program and deducts from total costs only those revenues received by the hospital from tuition.

42 C.F.R. § 413.85(c) also recognizes, as a general concept, that the community ultimately should bear the cost of such educational programs. The regulation does not define what constitutes community support or otherwise set an accounting standard by which such support can be quantified and deducted from the allowable costs of GME programs. The Secretary, however, has sought to elevate this general concept into an unjustified rule of law whereby revenues received from grants and state funding can be offset against the allowable *indirect* costs of these programs if such costs are incurred through the use of faculty, facilities, and other resources of a college of medicine.

In addition, the Third Circuit has misinterpreted the redistribution principle embodied in 42 C.F.R. § 413.85(c), which provides that although the Medicare program will "share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations," the program will not participate in "increased costs resulting from redistribution of costs from educational institutions . . . to patient care institutions." The Third Circuit has held that this principle means a provider must prove that it has historically incurred, paid, and reported GME costs in order to avoid the regulation's prohibition against redistributing costs from educational units to patient care units. In so doing, the Third Circuit has ignored the plain language of the regulation, which reflects that it is *the educational activities themselves* which must be customary and traditional, not the provider's practice of paying for them.

The Third Circuit's judgment also runs afoul of Medicare's requirement that costs must be properly allocated between Medicare and non-Medicare beneficiaries. 42 U.S.C. § 1395x(v)(1)(A). Its holding that Medicare is not obligated to share in the indirect costs which a hospital necessarily incurs as a part of its GME program means that these costs inevitably will be improperly shifted to non-Medicare beneficiaries.

Finally, the Third Circuit erroneously held that a failure to claim reimbursement for these indirect costs in the past creates an irrebuttable presumption that these costs have been absorbed by the community. This holding quite simply has no basis in law. In addition, it would permit the Secretary to act in an arbitrary and capricious fashion, perhaps even violating due process, by simply ignoring any relevant or even substantial evidence to the contrary.

In contrast to the decision of the Third Circuit in this case, the Sixth Circuit Court of Appeals has correctly recognized that the same indirect costs at issue here are allowable. The Sixth Circuit's approval is not only consistent with the language of 42 C.F.R. § 413.85, but also is consistent with the Medicare Act's prohibition against cost-shifting and other relevant Medicare regulations. *See Ohio State University v. Secretary, DHHS*, 777 F. Supp. 582 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir.), *petition for cert. filed*, 62 U.S.L.W. 3399 (U.S. Nov. 1, 1993) (No. 93-696). The Court should adopt the Sixth Circuit's proper interpretation and application of federal Medicare law as its own rule of decision in this case.

ARGUMENT

The overhead costs of graduate medical education programs are costs incurred by every teaching hospital that conducts a GME program.[1] They are costs that the Secretary recognizes are properly recoverable by a "stand

[1] These costs generally consist of allocated administrative costs (indirect costs allocated to clinical departments and not duplicative of university overhead allocated to the hospital); salary and fringe benefit costs of professional non-physician working staff (business office managers, programmers who support faculty members, etc.); salary and fringe benefit costs of clerical personnel and secretaries who work for the faculty members and professional staffs; space costs (depreciation, utilities, and related costs of offices and support areas used by faculty members) allocated on a square footage basis; and expenses for supplies that are consumed by the clinical departments of the educational unit.

alone" teaching hospital, that is, one that operates its GME program with its own teaching staff and resources. *Ohio State University*, 777 F. Supp. at 588-89. Yet the Secretary unjustifiably seeks to deny reimbursement for these same costs to teaching hospitals whose GME programs are conducted through colleges of medicine, the majority of which are State institutions.[2] The Secretary has claimed, and the Third Circuit has found, that permitting recovery of these costs would provide an impermissible benefit to a college of medicine rather than a proper reimbursement for the allowable costs of the teaching hospital. This position lacks merit in fact and in law.

Acceptance of the Secretary's position results in discriminatory treatment of teaching hospitals that operate their GME programs through related educational facilities. As the Secretary fully understands, this position has a particular adverse effect on State university hospitals that have traditionally conducted their GME programs through existing educational units of the university.

42 C.F.R. §§ 413.85 and 413.17[3] mandate that a hospital be reimbursed its reasonable direct and indirect costs

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[2] In response to the petition for writ of certiorari, the Secretary recognizes that the current issue affects approximately 17 hospitals – 10 of which are State university teaching hospitals. Brief of Respondent on Petition for Writ of Certiorari at 10-11.

[3] The Medicare "reasonable cost" regulations were originally codified at 20 C.F.R. Pt. 405 (1967). They have been redesignated twice – first at 42 C.F.R. Pt. 405 (1977), *see* 42 Fed. Reg. 52,826 (1977), and most recently at 42 C.F.R. Pt. 413 (1986), *see* 51 Fed. Reg. 34,790 (1986). Neither redesignation affects the substance of the regulations at issue in this case, and the amici will refer to the regulations as currently codified.

with respect to the provision of patient care services as part of the hospital's educational activities. Contrary to the arguments advanced by the Secretary, and as discussed further *infra*, the definition of reasonable costs of educational activities provided in Medicare law establishes that State subsidies, grants, and donations do not constitute "community support" of the hospital's educational program such as to preclude reimbursement by the Medicare program of its fair share of these costs. Nor do the facts that these costs were initially incurred by a college of medicine on behalf of the provider, or that they were inadvertently not claimed in the past, reflect "community support" of the provider's educational program or an improper "redistribution" of costs from an educational unit to a patient care unit. Rather, recovery of the GME overhead costs at issue in this case is consistent with the plain language of the applicable regulations, their history, and existing statutory and case law, including the recent decision of the Sixth Circuit in *Ohio State University, supra*.

I. TRADITIONAL UNIVERSITY FUNDING DOES NOT CONSTITUTE "COMMUNITY SUPPORT" SO AS TO PRECLUDE MEDICARE PARTICIPATION IN A TEACHING HOSPITAL'S GME PROGRAM

42 C.F.R. § 413.85(c) and (g) recognize Medicare's obligation to participate in GME programs. These regulations provide, in part, as follows:[4]

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[4] The final sentence of section (c), referred to as the "redistribution principle," has not been quoted. Rather, it has been set out and discussed in Section II of this brief.

(c) Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's need for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. *Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities.* . . .

(g) Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, *a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities* as determined under Medicare cost-finding principles. . . . (emphasis added)

The Third Circuit's judgment would allow the Secretary to deny Medicare reimbursement to State-funded teaching hospitals for undisputedly allowable indirect costs of their GME programs. It does so by accepting the Secretary's argument that prior State funding constitutes proof that the community has already assumed responsibility for these costs.[5] "In essence, the Secretary's decision interprets community support as any source of

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[5] The direct costs of the GME programs, such as compensation to teaching physicians, that have been incurred by teaching hospitals through colleges of medicine have been considered allowable costs and have been reimbursed by the Medicare program despite the fact of State funding. *Ohio State University v. Secretary, DHHS*, 777 F. Supp. 582, 588 (S.D. Ohio 1991), *aff'd*, 996 F.2d 122 (6th Cir.), *petition for cert. filed*, 62 U.S.L.W. 3399 (U.S. Nov. 1, 1993) (No. 93-696); *Thomas Jefferson v. Shalala*, No. 93-120 (U.S. filed July 20, 1993), *petition for writ of cert.*, app. at 11a, n.5; *The Board of Regents of the University of Minn. d/b/a University of Minn. Hosp. and Clinic v. Shalala*, 837 F.Supp 303 (D. Minn. 1993). In initially denying teaching hospitals claims for indirect costs, the Secretary stated that the basis for the denial was that direct costs were recoverable but that "indirect" costs were not. *In the Case of: Thomas Jefferson University*, Decision of the Administrator (Nov. 17, 1989), as cited in *Thomas Jefferson University v. Shalala*, No. 93-120 (U.S. filed July 20, 1993), petition for writ of cert., app. at 36a; *In the Case of: Ohio State University*, Decision of the Administrator, Medicare & Medicaid Guide (CCH) Para. 38,907 at 24,369 (Oct. 15, 1990); *In the Case of: University of Minn.*, Medicare & Medicaid Guide (CCH) Para. 39,420 at 26,829 (May 29, 1991). Perhaps recognizing that this argument lacked any support in Medicare law, the Secretary has not asserted it at the judicial level. *See* Secretary's Petition for Writ of Certiorari in *Ohio State University v. Shalala*, No. 93-696 (U.S. filed Nov. 1, 1993) at 6, n.5 and question presented in Respondent's Brief in response to petition for writ of certiorari in *Thomas Jefferson; see also Ohio State University v. Secretary, DHHS*, 996 F.2d at 124 ("The plain meaning of 42 C.F.R. § 413.85(c) is to authorize reimbursement of all direct and indirect costs. . . . ").

funding other than the Medicare program." *In the Case of: Thomas Jefferson University*, Medicare & Medicaid Guide (CCH) Para. 40,294 at 30,964, (E.D.Pa. May 1, 1992), *aff'd without opinion*, No. 92-1513 (3rd Cir.), *cert. granted*, 62 U.S.L.W. 3451 (U.S. July 20, 1993) (No. 93-120). This interpretation, however, is contrary to law, inappropriately penalizes a select number of university affiliated teaching

hospitals, and is inconsistent with the Secretary's treatment of other GME program costs.

A. Neither the Language of 42 C.F.R. § 413.85 Nor Its History Justifies Defining the Term "Community Support" to Mean State Subsidies, Grants, or Donations

There is nothing in the language or background of 42 C.F.R. § 413.85 to support an argument that the types of institutional funding ordinarily received by a university teaching hospital – such as State subsidies, grants, and donations – constitutes "community support" of the hospital's GME program so as to preclude the hospital from being able to include its GME overhead costs as allowable costs for purposes of Medicare reimbursement. On the contrary, 42 C.F.R. § 413.85(c) recognizes that many Medicare providers engage in educational activities and incur the costs related to those activities. The regulation states that although the costs of educational activities should be borne by the community rather than the teaching hospital, Medicare will pay its fair share of the costs incurred by the teaching hospital until the community assumes responsibility for them. The costs incurred in this case are costs incurred by the teaching hospital and not costs borne by the community.

42 C.F.R. § 413.85(c) does not define the term "community support," does not provide a mechanism for the offset of community support, and does not provide a mechanism for identifying sources of community support or for measuring the amount given. In contrast, section

(g) of the same regulation specifically provides the formula for calculating allowable costs of educational programs. That formula starts with the inclusion of the total direct and indirect costs of the educational programs and then deducts from total costs only the revenues received from tuition. As explained, *infra*, prior versions of 42 C.F.R. § 413.85(g) also had deducted from total direct and indirect educational costs the revenues received from grants and donations. These deductions, however, were eliminated by amendment to § 413.85(g) prior to the cost reporting period in question. Clearly, if "community support" was also intended to be offset, the regulation would provide comparable language.

The history of the regulation does not support the offset of grants, donations and State subsidies. As originally enacted, 42 C.F.R. § 405.421(b)(2) provided that net allowable educational costs were determined by deducting grants, tuition, and specific donations from the cost of approved educational activities. By amendment dated August 5, 1980, this section was revised (and redesignated paragraph (g)), to eliminate the deduction for certain donations for internships and residency programs. 45 Fed. Reg. 51,783 at 51,786 (1980). By amendment dated January 3, 1984, the deduction of grants and certain donations was eliminated in its entirety. 49 Fed. Reg. 234 at 296 (1984). These deletions clearly indicate that such funds are *not* to be offset in determining those costs which are properly reimbursable.

Unrestricted State subsidies have always been exempt from offset against allowable educational costs:

> Whether or not they are characterized as a 'grant' or 'gift,' funds transferred to a provider from another component of the same organizational entity – e.g., from a university to the university hospital or from a State agency to a State university hospital – are not considered a grant or gift for Medicare reimbursement purposes but rather an internal transaction amounting only to self-financing of the entity's own component operations, thus having no effect on the provider's allowable costs. . . .

Section 607, Provider Reimbursement Manual. Thus, the Third Circuit's decision that "community support" can be defined to include State subsidies is plainly incorrect.[6] This supposed basis for denying allowable indirect costs of GME programs is inconsistent with both 42 C.F.R. § 413.85 and the governing Medicare program instructions.

The reason for subsequently exempting restricted grants and State subsidies from offset as of October, 1983 was clearly set forth in the preamble to the revision:

> Since the offset of donor restricted contributions appears to dilute the effect of the contribution, it may discourage private philanthropy. Because we believe it is in the best interests of needed health care to increase private sector support of

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[6] State subsidies are often necessary to support State-teaching hospitals because of the disproportionate level of indigent care provided in such institutions. In the absence of State subsidies, the revenues received from patients with insurance coverage (including Medicare) and independent resources would be insufficient to cover the costs of operating the teaching program.

> health care institutions, we are eliminating Sec. 405.423 [which required the offset of restricted grants, gifts and income from endowments]. As a result, restricted grants and gifts will no longer be used to offset costs effective with cost reporting periods beginning on or after October 1, 1983.

48 Fed. Reg. 39,752 at 39,797 (1983).

Until the current dispute, the Secretary had consistently followed the position of not offsetting State subsidies and grants against GME costs, as is evident from the regulation's more recent history. In September of 1989, in response to concerns about whether medical schools, which were adequately funded by grants from State and local governments, should be permitted to pass through their GME costs to the hospital, the Secretary stated:

> With respect to the comment that we should address the issue of funding that covers the costs of operating the medical school, our policy prior to October 1, 1983 provided that restricted grants . . . were deducted from the designated costs incurred by the provider. Unrestricted contributions, however, would not be deducted from such costs. Section 901 of the Omnibus Budget Reconciliation Act of 1980 (Pub. L. 96-499) added section 1134 of the Act. This provision affirmed the Secretary's authority not to offset donor-restricted grants and gifts that the Secretary finds, in the best interests of needed health care, should be encouraged. The policy that restricted grants could be offset against allowable costs incurred by providers was changed effective October 1, 1983. . . .

> Thereafter, any grant monies received by a provider could not be offset against the reimbursable amounts due the provider under Medicare.

54 Fed. Reg. 40,286 at 40,302 (1989).

Based upon the above, it is clear that traditional funding received by teaching hospitals is not to be offset against allowable costs. Further, it is undisputed that these types of funding have historically not acted as a bar to the recovery of the direct costs of a teaching hospital's approved GME program. *See supra* note 5. Thus, the Secretary's claim in this case that this traditional funding establishes that the community has undertaken responsibility for the GME overhead costs at issue is both novel and wrong, and her decision to deny Medicare reimbursement for such costs is not only without legal justification but also is internally inconsistent.[7] Despite these facts, and without any explanation as to how any such imaginary distinctions can be made, the Third Circuit incorrectly held that the Secretary's position permitting offset is "reasonable." *Thomas Jefferson*, Medicare & Medicaid Guide (CCH) Para. 40,294 at 30,965.

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[7] Even in light of the Secretary's arbitrary position, factual differences may arise with respect to the various cases that are currently pending on this issue before this Court and the lower federal court. For example, the Secretary specifically relied upon the "community support" principle in *Thomas Jefferson*. The Secretary specifically did not rely upon the "community support" principle in *Ohio State University, supra*, a case in which State funding is limited to an unrestricted State subsidy. Even if the Court was to find any merit in the Secretary's position, therefore, differences such as this reflect the importance of the Court at least creating a standard that allows each case to be judged in light of its individual facts.

B. The Secretary's Interpretation of the Meaning of "Community Support" as Set Forth in 42 C.F.R. § 413.85(c) Violates 42 U.S.C. § 1395x(v)(1)(A)

The Third Circuit's interpretation of the "community support" language of 42 C.F.R. § 413.85(c) as a means of avoiding Medicare's participation in patient-related educational programs contravenes fundamental statutory principles of Medicare law. 42 U.S.C. § 1395x(v)(1)(A) provides that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered." This statute specifically prohibits the direct and indirect costs of delivering health care services to Medicare beneficiaries from being shifted away from Medicare beneficiaries and being imposed instead on non-Medicare beneficiaries.

As recognized in 42 C.F.R. § 413.85(c), GME training affords benefits to both Medicare and non-Medicare patients in terms of enhanced quality of care. Medicare reimbursement for the indirect costs associated with graduate medical training, which benefits Medicare patients directly, is necessary to properly allocate the cost of such training between Medicare and non-Medicare beneficiaries consistent with 42 U.S.C. § 1395x(v)(1)(A). The Secretary's disallowance of these costs necessarily shifts these costs improperly onto non-Medicare beneficiaries:

> By reimbursing the Hospital for the portion of clinic training which the residents receive and pass on to their Hospital Medicare patients in terms of enhanced quality of service, costs are *properly* shifted to the patient care institution

> and its Medicare beneficiaries. This comports with the underlying statute, 42 U.S.C. § 1395x(v)(1)(A), which prohibits shifting necessary *direct or indirect costs* of providing services from Medicare beneficiaries to non-Medicare beneficiaries. . . . The Hospital seeks only reimbursement for the *allocable* share of costs, *i.e.*, the costs equal to the proportion of Medicare patients at the Hospital relative to the Hospital population. *See* 42 C.F.R. § 405.402(a) (1982) (emphasis added).

University of Cincinnati v. Bowen, 875 F.2d 1207, 1210 (6th Cir. 1989). *See also St. John's Hickey Memorial Hosp. v. Califano*, 599 F.2d 803, 807 (7th Cir. 1979) (finding Secretary's community support position in contravention of cost-shifting principle given that clear weight of evidence established that the provider was not the recipient of community-supported financing for a nursing education program operated by the provider in conjunction with a local educational institution); *Los Alamitos General Hosp. v. Donnelly*, 558 F. Supp. 1141, 1145 (D.D.C. 1983) (finding that since nursing services are provided to both Medicare and non-Medicare patients, disallowance of the costs of the nursing program would violate 42 U.S.C. § 1395x(v)(1)(A)).

Accordingly, in an attempt to avoid Medicare reimbursement of allowable GME overhead costs, the Third Circuit has erroneously interpreted the term "community support" as set forth in 42 C.F.R. § 413.85(c). The Third Circuit's interpretation is not only inconsistent with the plain language of the regulation and the Secretary's past interpretation of what constitutes net costs, but also violates Medicare's cost-shifting principle as set forth in 42 U.S.C. § 1395x(v)(1)(A).

II. THE REDISTRIBUTION PRINCIPLE DOES NOT SUPPORT THE DENIAL OF MEDICARE PARTICIPATION TO THOSE EDUCATIONAL *ACTIVITIES* WHICH ARE CUSTOMARILY OR TRADITIONALLY CARRIED ON BY TEACHING HOSPITALS IN CONJUNCTION WITH THEIR GME PROGRAMS

42 C.F.R. § 413.85(c) not only recognizes the importance of Medicare participation in educational activities but also recognizes the importance of limiting Medicare participation to those educational activities which are a customary part of a hospital's teaching program. This concept is referred to as the "redistribution principle" and is set forth in the final sentence of 42 C.F.R. § 413.85(c) as follows:

> Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

The plain meaning of this language "is to allow providers to receive reimbursement for a fair share of all direct and indirect costs related to educational activities customarily or traditionally carried on by providers in conjunction with their operations." *Ohio State University*, 996 F.2d at 124.

Teaching hospitals traditionally and customarily engage in the clinical training of interns and residents in

the hospital setting, as well as training programs involving other health care occupations such as nursing, occupational therapy, pharmacy, physical therapy, and x-ray technology. In contrast, educational institutions customarily engage in classroom training, undergraduate medical education, or other nonclinical educational activities. As the district court recognized in *Ohio State University*, the "activities customarily or traditionally carried on by providers" includes such clinical training programs for interns and residents:

> In the case of graduate medical education, it would be customary and traditional for a teaching hospital to employ qualified physicians in various medical specialties to select and supervise the interns and residents enrolled in the educational program. These physicians would need clerical and administrative staff, office space and supplies to carry out their function. Their salaries, the salaries of their clerical and administrative staffs, and the cost of their office space and supplies would all be part of the cost of the educational activity which ultimately contributes to the quality of patient care in the hospital. . . . These would be the kind of costs Congress intended that the Medicare program should participate in.

Ohio State University, 777 F. Supp. at 587.

Under this straightforward interpretation of the redistribution principle, such costs should be disallowed only when it is shown that the costs for which reimbursement was claimed included those purely for educational institutions unrelated to patient care. *Id.* In contrast, when the evidence establishes that such costs are related

to providing patient care, then they are not an improper redistribution. Rather, they are "reimbursable under 42 U.S.C. § 1395hh and 42 C.F.R. § 413.85(g), which allow recovery of costs of providers of medical services relating to patient care." *Ohio State University*, 996 F.2d at 125.

The Third Circuit's decision has wrongly interpreted this provision to mean that if GME overhead costs are incurred by a college of medicine as part of a hospital's GME program and have not been previously claimed by the hospital as an allowable cost, then an irrebuttable presumption arises that the community has undertaken responsibility for these costs. Continuing with this analysis, the Secretary argues that to permit the provider to recover these costs now would result in an inappropriate "redistribution" of costs from the community to the Medicare program. *See* Brief in Opposition to Petition for Writ of Certiorari at 8-9.

As discussed below, the Secretary's argument is inconsistent with the Secretary's prior reimbursement of direct costs, contravenes the plain language of 42 C.F.R. § 413.85, and is arbitrary and capricious. This Court should not adopt the Third Circuit's error in blindly accepting the proposition that costs incurred by a college of medicine in operating a hospital's GME program constitutes costs of the "community" for purposes of 42 C.F.R. § 413.85(c)'s redistribution principle.

A. 42 C.F.R. § 413.17 Permits a Provider to Recover Allowable Direct and Indirect Costs Incurred by a Related Entity for Services, Facilities, and Supplies Furnished to the Provider

42 C.F.R. § 413.17 provides:

> (a) Except as provided in paragraph (d) of this section, *costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization.* However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.
>
> * * *
>
> (c)(2) If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, *in effect the items are obtained from itself. . . . Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization.* (emphasis added)

This provision, referred to as the "related party principle," expressly authorizes Medicare reimbursement for the costs of services, facilities, and supplies furnished to a provider by any organization related to the provider by common ownership or control. This principle simply recognizes that there is, in reality, only one organization. The purpose of this regulation is to ensure that the amounts

claimed for reimbursement are limited to the specific costs incurred by the related organization.[7]

The Secretary historically has not contested the applicability of this principle to the *direct* costs of a teaching hospital's GME program that are incurred by a related college of medicine. Rather, the Secretary has routinely provided reimbursement for allowable direct costs claimed on behalf of a related entity.[8] *See supra* note 5.

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[7] For example, in *Ohio State University*, although the Medicare regulations do not require transfers of funds between related entities, the hospital does transfer funds to the college of medicine as part of the hospital's bookkeeping procedures. *See* 777 F. Supp. at 585. Because the entities are related, however, the hospital cannot claim the entire amount of the transfer as an allowable Medicare cost. Rather, the hospital can claim only the specific costs incurred by the college of medicine in operating the hospital's GME program.

[8] The shifting nature of the Secretary's position raises serious due process concerns. For example, in *Ohio State University, supra*, the intermediary recognized the GME overhead costs as costs of the hospital and did not deny reimbursement on the basis that they had been incurred by a related entity. Rather, the intermediary's position was that a failure to claim the costs in the past constituted an absolute bar to claiming such costs now. The Administrator, without any discussion of the related party principle, disallowed the costs on the basis that they were (a) community-supported educational costs, and (b) indirect costs. Accordingly, if the Court were to find any legal basis for setting aside the related party principle in the isolated instance of a provider seeking to recover indirect costs which had not been claimed in the past, the Court should further consider whether the hospitals so affected should be given the opportunity to offer proof about responsibility for these costs (such as by way of internal transfers or through continued GME program financial deficits) in order to have the opportunity to defeat any erroneous "presumption" of community support.

Nor is there any language in either 42 C.F.R. § 413.17 or 42 C.F.R. § 413.85 which provides for a distinction between direct costs and the kinds of indirect costs which are presented in this case. Instead, 42 C.F.R. § 413.85(g) expressly authorizes reimbursement of the indirect costs which are at issue here:

> (g) Calculating net costs. Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, *and other direct and indirect costs of the activities* as determined under the Medicare cost-finding principles in § 413.453. (emphasis added)

As the Sixth Circuit correctly held in *University of Cincinnati*: "The costs of approved educational activities, such as stipends paid to residents *and related overhead*, are ordinarily included as reasonable costs." 875 F.2d at 1208 (emphasis added); *see also Ohio State University*, 777 F. Supp. at 588 ("Clearly, both direct and indirect costs of approved educational activities are reimbursable under § 413.85(g). It makes no sense to say that direct costs are reimbursable if incurred by a provider or a related medical school but that indirect costs are reimbursable only if incurred by the provider.")

Accordingly, the governing law dictates that reimbursement is to be made whenever a teaching hospital establishes these controlling facts:

> (1) the medical school is a related entity,
>
> (2) the Secretary has approved reimbursement for the direct costs of the GME program provided by the medical school, and
>
> (3) the indirect costs being sought are the same as would be allowed by a stand-alone community hospital.

Under these clear standards, there is no basis in law for denying such reimbursement in this case.

B. A Mistaken Failure to Claim Allowable Costs in the Past Cannot Constitute an Absolute Bar to Claiming Such Costs in the Future

The Secretary has taken the extrastatutory position that the related party principle is to be set aside in the isolated instance of a teaching hospital seeking to recover the indirect costs of its GME program where the hospital conducts its program through a college of medicine and has not sought Medicare reimbursement of these costs in the past. The Secretary's position is based upon a presumption that the failure to claim these costs in the past, regardless of the reason, absolutely proves that the "community" has supported the GME program,[9] and that to

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[9] Such an argument places a provider in the extremely difficult task of proving a negative. It is comparable to saying that because an individual failed to claim a business deduction in the past, the individual did not personally incur the expense. Thereafter, the individual will be barred from subsequently amending the income tax return in question unless the individual can prove that no one else paid the expense, with the added imposition that a receipt and statement that the expense was

permit reimbursement would result in an improper "redistribution" of costs. The Third Circuit accepted the Secretary's position because it mistakenly perceived a conflict between the related party principle of 42 C.F.R. § 413.17 and the redistribution principle of 42 C.F.R. § 413.85. Yet the Third Circuit's misinterpretation of the related party principle lacks legal authority, distorts the plain language of the redistribution principle, and violates basic principles of Medicare law.

1. The Secretary Cannot be Permitted to Arbitrarily Refuse to Consider Evidence

Federal courts have consistently held that there is no basis in law for the Secretary to refuse to consider Medicare reimbursement of previously unreported GME program costs despite evidence explaining the prior failure to claim such costs. "Where a provider gives a legitimate explanation for its failure to report or claim the costs in prior years, a refusal to consider the allowability of the costs is arbitrary and capricious." *Ohio State University*, 777 F. Supp. at 588.

For example, in *St. John's Hickey Memorial Hosp., supra*, the hospital had initiated a joint nursing education program with an unrelated local college. The intermediary disallowed the hospital's portion of the costs, stating that they had been borne by the "community" and would therefore constitute a redistribution. The PRRB rejected the intermediary's argument and held that the costs were

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individually incurred will always be judged as insufficient proof of the point.

reimbursable. The Administrator, as in the present case, reversed on the ground that the program was community supported. In reversing the Administrator, the Seventh Circuit Court of Appeals stated:

> The Secretary's conclusion that the program costs were unnecessary appears to be based solely on the theory that once a non-provider becomes the legal operator of the program, this establishes that the community has undertaken the costs of nursing education, so that it is unnecessary for the provider to continue to bear them. This theory is plainly contrary to the facts of the present case.

St. John's Hickey Memorial Hosp., 599 F.2d at 811 (citations omitted).

The same concerns were echoed by the Ninth Circuit in *Mercy Hosp. & Medical Center, San Diego v. Harris*, 625 F.2d 905 (9th Cir. 1980). In that case, a hospital sought partial reimbursement of deficits arising from the operation of an outpatient clinic on the basis that it constituted an educational activity. The Secretary had taken the position that the mere presence of patients constituted an absolute bar to being able to prove that the activity could qualify as an educational program. The Ninth Circuit disagreed: "A proper interpretation of HIM-15 . . . should allow a hospital to avoid the apparent bar to allocating such costs as educational costs upon a showing that the patient care activities involved are primarily dictated by the objectives of an overriding educational program. The Secretary's failure to allow for such a showing is arbitrary." *Id.* at 909.

A failure to permit a teaching hospital affiliated with a medical school to claim allowable costs simply because the hospital mistakenly failed to claim such costs in the past constitutes an arbitrary refusal on the part of the Secretary to consider evidence and to permit recovery on the basis of such evidence. It simply finds no basis in Medicare law.

2. The Third Circuit's Interpretation of the Redistribution Principle is Inconsistent with Basic Rules of Statutory Construction

It is a basic rule of statutory construction that every effort should be made to reconcile legislative enactments rather than to find that they are in conflict. *See, e.g., Connecticut National Bank v. Germain*, ___ U.S. ___, 112 S. Ct. 1146, 60 U.S.L.W. 4222, 4223 (1992) (as long as there is no "positive repugnancy" between two laws, a court must give effect to both); *Negonsott v. Samuels*, 933 F.2d 818, 819 (10th Cir. 1991), *aff'd*, 113 S. Ct. 1119 (1993) (statutes should be construed so that their provisions are harmonious with each other); *United States of America v. Caldera-Herrera*, 930 F.2d 409, 411 (5th Cir. 1991) (statutes must be read in harmony with one another so as to give meaning to each provision).

In the present case, the related party principle (42 C.F.R. § 413.17) and the redistribution principle (42 C.F.R. § 413.85) are readily reconcilable. Indeed, it is only by misconstruing the plain intent of the redistribution principle that the Third Circuit managed to hypothesize a conflict between them.

Recognizing that related parties are, in essence, a single entity, the related party principle permits a hospital to recover the *allowable* costs of services, facilities, and supplies furnished to the hospital by a related party and limits the amount of that recovery to the specific costs incurred by the related party. At the same time, the effect of the redistribution principle is to permit

> . . . reimbursement of all direct and indirect costs related to the kinds of educational activities customarily or traditionally carried on by providers, but to deny reimbursement for costs related to educational activities which are customarily or traditionally carried on by educational institutions, such as medical and nursing schools.

Ohio State University, 996 F.2d at 124.

As such, the redistribution principle makes it quite clear that allowable costs are *only* those educational costs related to patient care at the hospital. Medicare will not participate in costs unrelated to patient care, such as undergraduate instruction or other activities which are not customarily and traditionally carried on by providers. Interpreted in this manner, the redistribution principle is not only entirely consistent with and complimentary to the related party principle, but it also is consistent with 42 U.S.C. § 1395x(v)(1)(A), which prohibits providers from shifting the necessary direct and indirect costs of delivering health care services from Medicare beneficiaries to non-Medicare beneficiaries.

The Third Circuit's approach, which ignores the plain language of the redistribution principle "to share in the

support of educational activities customarily or traditionally carried on by providers in conjunction with their operations," unnecessarily and incorrectly places that principle in conflict with the related party principle and in conflict with Medicare's underlying cost-shifting principle. That misreading of Medicare law should not be approved by this Court. "The traditional deference courts pay to agency interpretation is not to be applied to alter the clearly expressed intent of Congress." *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988).

CONCLUSION

In order for educational activities to be reimbursable under the "plain language" of the Medicare regulations, they must:

> (1) be approved programs; (2) contribute to the quality of patient care within an institution; and (3) not redistribute costs from educational to patient care institutions.

University of Cincinnati, 875 F.2d at 1210.

A State university teaching hospital typically conducts its graduate medical education program by use of existing educational facilities and staff. Because it is an instrumentality of the State, the hospital obviously receives a portion of its funding from the State.[10]

[10] The State university teaching hospital is but one of many components of the State university system, the same as the college of medicine, the college of arts and sciences, the college of veterinary medicine, or the college of business administration. In the case of Ohio State University Hospitals, for example, the college of medicine is located in a building which is contiguous to the Hospital. In the case of the University of Minnesota, to give a different example, the college of medicine is located in the same building as the hospital but on a different floor.

The Secretary's argument that traditional sources of university funding bar State universities and those provider programs which work in conjunction with them from recovering what would otherwise be allowable Medicare costs would unfairly penalize these providers. The Secretary's further argument that the educational component of a single university will be treated as an independent source of community support, solely for purposes of assessing whether GME overhead costs will be reimbursable, would preclude university teaching hospitals from receiving the very same reimbursement that is routinely received by stand-alone community hospitals. These arguments have no basis in Medicare law, and the attempt to create these bars to recovery in a post hoc fashion not only constitutes arbitrary and capricious behavior by the Secretary but violates basic notions of due process.

Based upon the above, the amici curiae respectfully urge this Court to reverse the decision of the Court of Appeals for the Third Circuit in this case. Instead, the Court should embrace the proper and lawful approach adopted by the Court of Appeals for the Sixth Circuit in *Ohio State University, supra*, and hold that Medicare law requires the Secretary to pay a fair share of the

direct and indirect costs of the GME programs of teaching hospitals consistent with 42 C.F.R. §§ 413.85 and 413.17.

Respectfully submitted,

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APPENDIX

42 U.S.C. § 1395x

(v) Reasonable costs

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types of classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs

necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

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42 C.F.R. § 413.85
Formerly. . . .
42 C.F.R. § 405.421

§ 413.85 Cost of educational activities.

* * *

(b) *Definition – Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed if required by State law. If licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

(c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended

that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.

(d) *Activities not within the scope of this principle.* The costs of the following activities are not within the scope of this principle but are recognized as normal operating costs and are reimbursed in accordance with applicable principles –

(1) Orientation and on-the-job training;

(2) Part-time education for bona fide employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work;

(3) Costs, including associated travel expense, of sending employees to educational seminars and workshops which increase the quality of medical care or operating efficiency of the provider;

(4) Maintenance of a medical library;

(5) Training of a patient or patient's family in the use of medical appliances;

(6) Clinical training of students not enrolled in an approved education program operated by the provider; and

(7) Other activities that do not involve the actual operation of an approved education program including the costs of interns and residents in anesthesiology who are employed to replace anesthetists.

(e) *Approved programs.* In addition to approved medical, osteopathic, dental, and podiatry internships and

residency programs, recognized professional and paramedical educational and training programs now being conducted by provider institutions, and their approving bodies, include the following:

(f) *Other educational programs.* There may also be other educational programs not included in the foregoing in which a provider institution is engaged. Appropriate consideration will be given by the intermediary and the Health Care Financing Administration to the costs incurred for those activities that come within the purview of the principle when determining the allowable costs for apportionment under the health insurance program.

(g) *Calculating net cost.* Net costs of approved educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition. For this purpose, a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

(Secs. 1102 and 1371 of the Social Security Act (42 U.S.C. 1302 and 1396hh))

42 C.F.R. § 413.17

§ 413.17 Cost to related organizations.

(a) *Principle.* Except as provided in paragraph (d) of this section, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

(b) *Definitions* – (1) *Related to the provider.* Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) *Common ownership.* Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

(3) *Control.* Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(c) *Application.* (1) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence, and for other reasons. These goals may be accomplished by

means of ownership or control, by financial assistance, by management assistance, and other ways.

(2) If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

(d) *Exception.* (1) An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary (or, if the provider has not nominated a fiscal intermediary, HCFA), that –

(i) The supplying organization is a bona fide separate organization;

(ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;

(iii) The services, facilities, or supplies are those that commonly are obtained by institutions such as the

provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and

(iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(2) In such cases, the charge by the supplier to the provider for such services, facilities, or supplies is allowable as cost.

Federal Register/Vol. 45 No. 152 Tuesday, August 5, 1980

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 405

Medicare Program; Reimbursement for Costs of Approved Internship and Residency Programs

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule amends the regulation governing Medicare payments to providers of services for their costs of approved educational activities. Under the current regulation, providers are required to deduct all grants designated for specific education programs from their costs of those programs in calculating their costs that are reimbursed by Medicare. Under the amended regulation, providers will not be required to deduct grants for primary care internship and residency program. The rule is intended to avoid nullifying the purposes of specific grants for their programs.

The amended rule will also apply to Medicaid payments in those States that pay for costs of educational activities the same basis as Medicare.

EFFECTIVE DATE: January 1, 1978.

The reporting requirements in this regulation are subject to clearance by the Office of Management and Budget under the Federal Reports Act of 1942, and shall not be effective until that clearance is obtained. The

Department will publish a notice on (60 days after publication) advising the public of the outcome of the OMB review.

FOR FURTHER INFORMATION CONTACT:

William Goeller (301) 597-1802.

SUPPLEMENTARY INFORMATION:

Background

Under Medicare, a provider of services (a hospital, skilled nursing facility or home health agency) is reimbursed on the basis of the costs it incurs in furnishing services to Medicare beneficiaries. Current Medicare regulations specify that, in determining the costs reimbursed under Medicare, the provider may include its net costs of educational activities approved in accordance with the regulations at 42 CFR 405.421. Net cost is currently determined by deducting all grants, tuition, and specific donations from the provider's incurred costs for the educational activity (42 CFR 405.421(b)(2)). However, we have found that these deductions undermine the purpose of grant programs designed to support primary care internship and residency programs. Specifically, the deduction of a grant reduces the provider's costs recognized for Medicare reimbursement, thereby preventing the provider from realizing the full benefit of the grant. We believe this thwarts one of the purposes of title VII of the Public Health Service Act, which is to foster the development of programs designed to train physicians in primary care specialties. Therefore, we have changed the regulation to specify that deductions will not be made for grants and donations received to support these programs.

Instead, if hospital revenues for these programs exceed costs, HCFA will notify grant donors so they may make adjustments if called for. . . .

Application to Medicaid Payments

The amended regulation will apply to Medicaid payments made under State plans that require payment for education costs to be made on the same basis as Medicare. In other States, payments for education costs will continue to be made under the existing State plans.

42 CFR 405.421 is amended by revising paragraph (a), redesignating paragraph (b)(1) as paragraph (b), deleting paragraphs (d)(2) and (b)(3), and adding new paragraphs (g) and (h) to read as follows:

§ 405.421 Cost of educational activities.

(a) A provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section.

(b) *Definition – Approved educational activities.* Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

* * *

(g) *Calculating net cost.* (1) Except as specified in paragraph (g)(2) of this section, net costs of approved

educational activities are determined by deducting, from a provider's total costs of these activities, revenues it receives from tuition, and from grants and donations that the donor has designated for the activities. For this purpose a provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in § 405.453.

(2) Effective for cost reporting periods beginning on or after January 1, 1978, grants and donations that the donor has designated for internship and residency programs in family medicine, general internal medicine, or general pediatrics are not deducted in calculating net costs.

(h) *Reporting of costs and revenues.* Effective for costs reporting periods beginning on or after January 1, 1978, if a provider has received a grant or donation that the donor has designated for an internship or residency program in family medicine, general internal medicine, or general pediatrics, the following requirements apply:

(1) For each program for which the provider received a grant or donation, the provider shall report to its Medicare intermediary, in the form required by HCFA, the following information:

(i) The total direct and indirect costs the provider incurred for the program, as determined under the Medicare cost-finding principles in § 405.453;

(ii) The total revenues the provider received for the program, including tuition, grants and donations designated for the program, and patient care revenues attributable to the program, as calculated under paragraph (h)(2) of this section;

(iii) The amount of the difference between program costs and program revenues; and

(iv) The name and address of the donor of each grant or donation designated for the program, and the amount given by each donor.

(2) For purposes of the report required under paragraph (h)(1) of this section, the provider shall determine the portion of patient care revenues for each department that is attributable to an internship or residency program based on the ratio of that program's costs allocated to the department under § 405.453 to total costs allocated to the department under § 405.453.

(3) The Medicare intermediary will notify HCFA of the amount of any surplus of program revenues over program costs that a provider reports under paragraph (h)(1) of this section, and of the name and address of each donor that supported the program.

(4) If a provider reports a surplus for a program under paragraph (h)(1) of this section that is equal to or less than the amount of the grant the provider received for the program from the Public Health Service. HCFA will notify the Public Health Service of the amount of the surplus. If the surplus exceeds the amount of the grant the provider received for the program from the Public

Health Service, HCFA will notify the Public Health Service and other donors of the amount of the surplus. If the provider did not receive a Public Health Service grant for the program, HCFA will notify other donors of the amount of the surplus.

(Section 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) Catalog of Federal Domestic Assistance Program No. 13.773, Medicare - Hospital Insurance)

Dated: July 3, 1980.

Earl M. Collier, Jr.,

Acting Administrator, Health Care Financing Administration.

Approved: July 28, 1980.

Patricia Roberts Harris,

Secretary.

[FR Doc 80-23370 filed 8-4-80. 8 45 am]

BILLING CODE 4110-35-M

Federal Register/Vol. 48 No. 171 Thursday, September 1, 1983

E. Grants, Gifts, and Income From Endowments - § 405.423

Medicare policy concerning the treatment of grants and gifts has been in a state of transition for some time. As a general rule, grants and gifts that have been restricted by the donor to pay for a specific operating cost (or group of costs) have been used to reduce that cost. However, a number of exceptions to the general rule on the treatment of restricted contributions have been administratively established and implemented over time. The exceptions (which represent a liberalization of the rule) have resulted from situations where strict application of the general rule would not yield an equitable or desirable effect. These exceptions have included:

- Seed money grants;
- Deficit financing grants:
- Grants for primary care education programs;
- Contributions which benefit only non-Medicare patients; and
- Capital assets purchased with donated funds.

Except for grants for primary care education programs, the exceptions are not contained in the regulations, although they are being applied by the Medicare intermediaries.

The Omnibus Reconciliation Act of 1980 (Pub. L. 96-499) contained a provision dealing specifically with

hospital philanthropy. Section 901 set out the same general rule pertaining to those contributions which shall not be offset as our regulations contain. In addition, the section reaffirmed the Secretary's authority not to offset those types of donor-restricted grants and gifts which the Secretary finds, in the best interests of needed health care, should be encouraged.

The intent behind the general rule pertaining to restricted contributions is to prevent providers from receiving double payment for a given cost – once from the contribution and once from Medicare – and to permit the Medicare program to derive the same benefit from the contribution as do others. We believe the general rule no longer has a significant impact on Medicare program outlays.

Hospitals are the largest beneficiary of restricted grants and contributions. Under the prospective payment system, the treatment of the grants and contributions for purposes of determining reasonable cost will not affect Medicare reimbursement for impatient operating services.

Since the offset of donor restricted contributions appears to dilute the effect of the contribution, it may discourage private philanthropy. Because we believe it is in the best interests of needed health care to increase private sector support of health care institutions, we are eliminating § 405.423. As a result, restricted grants and gifts will no longer be used to offset costs effective with cost reporting periods beginning on or after October 1, 1983.

Federal Register/Vol. 49, No. 1 Tuesday, January 3, 1984

Comment – One commenter questioned whether paragraphs (g) and (h) of § 405.421, which deal with the treatment of grants and donations, should be removed as the result of the deletion of § 405.423 (Grants, gifts, and income from endowments) in the interim final rule.

Response – We agree that a revision is necessary. We have therefore revised § 405.421 by revising paragraph (g)(1) and removing paragraphs (g)(2) and (h). This change merely makes the regulations consistent with the change that was made in the interim final.

• *Grants, gifts and income from endowments* – Section 405.423 was eliminated effective for cost reporting periods beginning on or after October 1, 1983. As a result, restricted grants and gifts will no longer be used to offset costs. We received several comments commending us for making this change in policy. . . .

Federal Register/Vol. 54, No. 188 Friday, September 29, 1989

Comment: Some commenters expressed concern about treatment of GME costs of a related medical school. One commenter pointed out that, in some complexes, GME activities may take place in space assigned to the medical school, and that it would be unfair to impose a restriction on the location of allowable GME patient care activities in large academic health care centers for reimbursement purposes. Another commenter was concerned that medical schools often are adequately funded by grants from State and local governments, so it seems inappropriate for the medical school under such circumstances to also pass-through such costs to the hospital. In the opinion of the commenter, we should address whether there is a redistribution of GME costs when State appropriations or other funding sources are sufficient to cover the costs of operating the medical school.

Response: We agree that determination of allowable costs of related medical schools can be a complicated matter. We are guided by the general principle that to be allowable at all, the costs must be related to patient care furnished in the hospital, and, to be allowable as a direct GME cost, the costs must be related to the GME program in the hospital. Certain identifiable activities conducted by the faculty of a related medical school, which are necessary for the clinical training function at the hospital, may represent allowable costs for Medicare program purposes. These activities include supervision of interns and residents in activities for which no Part B charge is made and the conducting of rounds and patient care conferences related to hospital patients. To reiterate, services

that are both related to the care and treatment of the hospital's patients and furnished in support of the training of interns and residents meet the requirements for payment.

These items and services must be necessary and directly related to the provision of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, a portion of those costs that are incurred by the university medical school may be allowable if it can be demonstrated to the satisfaction of the fiscal intermediary that such costs are directly related to the training program of the interns and residents working in the university hospital and are related to the care and treatment of the hospital's patients.

In the past, hospitals have alleged that the related organization principle set forth in § 413.17 requires Medicare to reimburse a hospital for a share of all costs of a medical complex or even of the entire university on the basis that the component entities were indistinguishable from the whole. Our policy concerning related organizations was established to avoid program recognition of costs of a provider for services furnished by a related organization in excess of costs incurred by the related organization, and to avoid payment of artificially inflated costs that might be generated from less than arm's length bargaining. This policy was not intended to expand the range of items and services for which a provider could claim Medicare reimbursement, or to include items and services not specifically related to patient care.

With respect to the comment that we should address the issue of funding that covers the cost of operating the medical school, our policy prior to October 1, 1983 provided that restricted grants (those grants that were designated by the donor for paying certain specified provider costs) were deducted from the designated costs incurred by the provider. Unrestricted contributions, however, would not be deducted from such costs. Section 901 of the Omnibus Budget Reconciliation Act of 1980 (Pub. L. 96-499) added section 1134 of the Act. This provision affirmed the Secretary's authority not to offset donor-restricted grants and gifts that the Secretary finds, in the best interests of needed health care, should be encouraged. The policy that restricted grants could be offset against allowable costs incurred by providers was changed effective October 1, 1983 (as provided in the September 1, 1983 final rule (48 FR 39797)). Thereafter, any grant monies received by a provider could not be offset against the reimbursable amounts due the provider under Medicare.

[¶ 5451] TRANSFER OF FUNDS TO A PROVIDER BY ANOTHER COMPONENT OF THE SAME ENTITY (Prov. Reimb. Man., Part 1, § 607)

Whether or not they are characterized as a "grant" or a "gift", funds transferred to a provider from another component of the same organizational entity – e.g., from a university to the university hospital or from a State agency to a State university hospital – are not considered a grant or gift for Medicare reimbursement purposes but rather an internal transaction amounting only to self-financing of the entity's own component operations, thus having no effect on the provider's allowable costs.

However, such funds are considered a grant or gift subject to the rules in §§ 604 [¶ 5440] and 606 [¶ 5443] where the component from which the funds are received is not one which exercises fiscal control over the provider (e.g., a State health department vis-a-vis a State university hospital under the control of the State board of regents) and the funds could not otherwise legally be transferred to the provider by administrative action to supplement its regular funding (e.g., the funds come from appropriations by a State legislature that may be reallocated to supplement the provider's regular State funding only by further legislative action).

.01 Sources:

As adopted. Trans. No. 89 (June 1974)
